HOSPITAL Topics

RAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

Fire Prevention Program For Los Angeles Hospitals

first in a series

page 22

Disposables: Hospitals Find "Things Cheaper Than People"

page 28

How to Benefit from Short-Term Trusts

page 37

BUYER'S GUIDE
Page 66

W. STADEL, M.D., (see page 3)

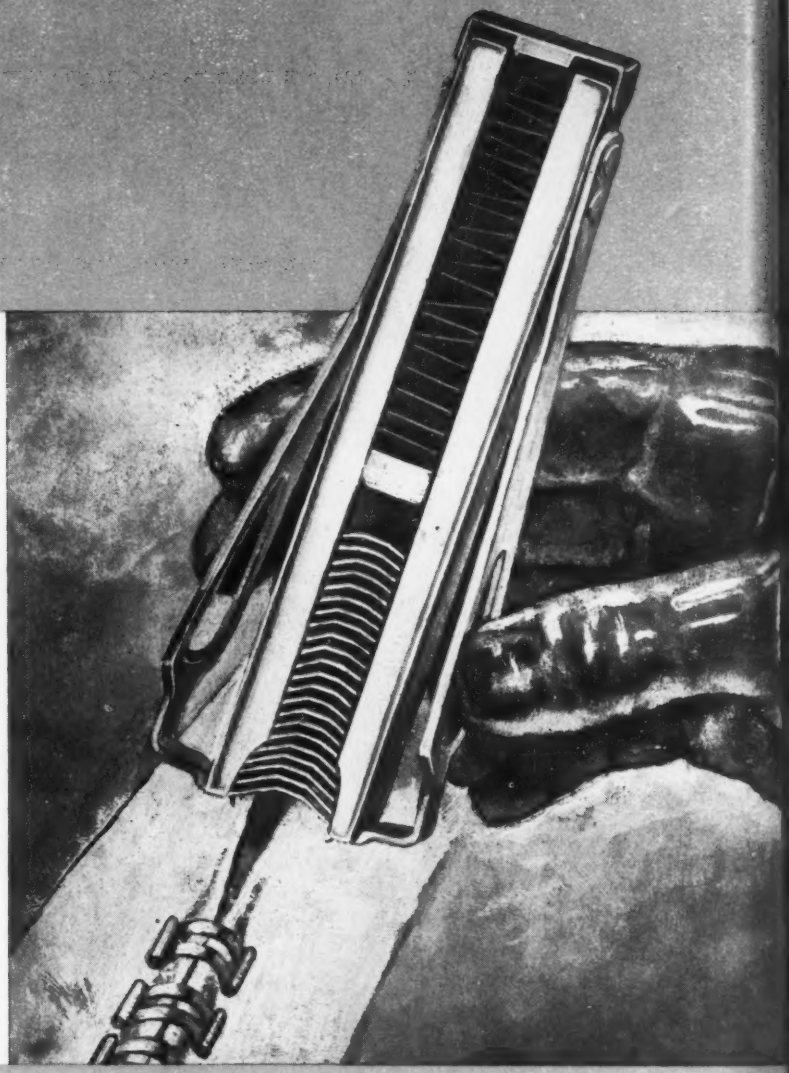
HA CONVENTION REPORT—*Special Section*

OCTOBER | 1957

AUTOCLIP APPLIER

for placement of wound clips...

AUTOMATICALLY



AUTOCLIPS® have all the advantages of fast, easy wound-clip skin closure: rapid healing; better cosmetic result; minimum of tissue trauma; easy, painless clip removal. The Autoclip Applier is lightweight, convenient, simple and fast!

AUTOCLIP APPLIER.....$23.50 **REMOVER.....$6.00**

AUTOCLIPS.....$2.40 per 100; $22.00 per 1000

Order from your dealer. He also stocks: **Intramedic Polyethylene Tubing**
CRI Germicide • Cantor Tube • Medichromes • Franklin Bilirubin Test

Clay-Adams NEW YORK 10

TOTCO®

Mr. K. J. Shoos, superintendent of the Saint Luke's Hospital in Cleveland, says "We are using our Hausted Tractionaids continuously . . . often treating seven patients a day. This equipment has proved convenient to operate; it may be taken to the patients' beds. Our doctors like the results of the treatments, and the patients tell us traction with Tractionaid is comfortable."

RESULTS OF TRACTIONAID TREATMENTS PLEASE ST. LUKE'S HOSPITAL DOCTORS

The above statement is typical of the comments made wherever the new Hausted TRACTIONAID is being used clinically.

Because the TRACTIONAID is electronically controlled and hydraulically operated, it offers the ultimate in improved traction therapy. It permits smooth, even, steady or intermittent traction . . . at exactly the pull and time interval prescribed. Traction from 1 to 100 pounds may be pre-set. Extreme flexibility of application makes pelvis or cervical traction simple. Indicated wherever traction or manipulation is desired.

Only Hausted TRACTIONAID automatically compensates for patient's movement during treatment!

For complete data and clinical reports write to:

Tomorrow's Equipment Today

The

HAUSTED MANUFACTURING COMPANY

Medina, Ohio

HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

OCTOBER, 1957, VOL. 35, NO. 10

FEATURES

Report on International College of Surgeons 17

Abstracts of selected papers:

Technic Extends Time for Heart Stoppage Under Hypothermia
Kazumi Taguchi, M.D.

Replaced Heart in Dog Beats for Two Hours
Edgar F. Berman, M.D., Mauricio Goldberg, M.D., and Leonard Akman, M.D.

Vitamins Given in Attempt to Prevent Cleft Lip, Palate
Lyndon A. Peer, M.D.

Scanning the News — See page 7

Conventions — See page 17

Pediatrics — See page 99

Report on American Surgical Trade Association 20

Fire Prevention Program for Los Angeles Hospitals, Part I 22

Every Hospital Needs a Fire Safety Program 26
Robert H. Wright

Disposables: Hospitals Find 'Things Cheaper than People' 28
Harry K. DeWitt

Paper Container Gains Wide Acceptance in Food Service 31
Browne Sampsell

How Hospitals Can Benefit from Short-Term Trusts 37
Second in a series on public relations and fund-raising
Bernard Tomson and Herman Jaffe

Business Office Operations—Accumulation of Patient Charges 43
John H. Gorby

Ready Reference of Hospital Facts 45
Facts on the Average Federal General Hospital in the U. S.
Louis Block, Dr. P.H.

Consultant's Corner 48
John G. Steinle

G. M. Marshall, Publisher
J. F. Fleming, M.D., Medical Editor
Marie Jett, Editor
John G. Steinle, Consulting Editor

Barbara Work, Production Manager
Nina Marie Stein, Associate Editor
Helen Lundin, Advertising Production Manager

Gunhild Moberg, Business Manager
Marcella Skandis, Assistant to the Publisher
Virginia Page, Advertising Representative
John Hogensen, Advertising Representative

Published by THE HOSPITAL BUYER CO., Inc., 30 West Washington St., Chicago 2, Ill. Telephone: DEarborn 2-5148. Eastern Sales Office: 7 W. 44th St., New York City. Telephone OXford 7-5262. Subscription rates: one year, $3.50; three years, $8.00; single copy, 50 cents. Canadian and foreign subscriptions: one year, $4.50; three years, $10.00; single copy, 65 cents. A monthly publication. Entered as second class matter at the Post Office, Chicago, Ill.

DEPARTMENTS

Scanning the News 7

News Briefs at Press Time 9

Calendar of Coming Events 10

Personally Speaking 50

Review of Hospital Law Suits 53
Leo T. Parker

Hospital Accounting and Statistical Problems 56
David H. Tarlow, C.P.A.

Trade Topics 58

Buyer's Guide 66

New Literature 73

Prescription Pad 86

Clinical Notes 88

O.B. Department 91
The Physical Therapist on the Obstetric Team
Mrs. Eileen Montgomery

Book Corner 96

Pediatrics 99
Emphasize Personal Aspect in Care of Handicapped
Anne Seymour, R.N. and Pauline Wright, R.N.

The Lab 123
Applying Industrial Methods in Hospital Laboratory Operations
Arthur Allen

Central Supply 131
Disposable Needles Meet Need for Sharpness, Sterility
Randall B. Tinker and Richard A. Hill

Index to Advertisers 136

OPERATING ROOM

Planning the New 'Philadelphia Story' 107

Nationally-Known Surgeons Named as AORN Speakers 108

Ethylene-Oxide Sterilization in Ophthalmology 110
R. A. Skeehan, Jr., Lt. Col. (MC), J. H. King, Jr., M.D., and Saul Kaye, A.B.

Selected Bibliography (Ophthalmic Procedures) 115

O.R. Question Box—Carl W. Walter, M.D. 116

PERSONALITY OF THE MONTH

W. STADEL, M.D., director, San Diego County (Calif.) Department of Medical Institutions, will wind up his year as president, California Hospital Association, at that organization's annual convention, October 30-November 3, in Long Beach.

Association achievements which he considers especially noteworthy during his term include: development and furtherance of a statewide uniform accounting program; successful lobbying during the state legislature's recent session, resulting in the defeat of several bills unfavorable to hospitals and/or medicine, and passage of a pharmacy bill important to small hospitals; and continued expansion of the joint liability insurance program.

A graduate of the University of Kansas School of Medicine, Dr. Stadel entered the hospital administration field as an intern at Alameda County Institutions, Oakland, Calif., in 1940, after two years of private practice. He was assistant medical director when he left there in 1948 to become administrator, San Diego County General Hospital. He has held his present position since July, 1955.

Dr. Stadel is a past president of the San Diego Hospital Conference, a fellow of the American College of Hospital Administrators, and a member of the American Hospital Association and the Association of Western Hospitals. He has been serving on the AHA's Council on Professional Practice, and is chairman of that group's committee on chronic illness.

He is president, California State Board of Vocational Nurse Examiners, and an associate member of national, state, and local medical organizations, and has been active in many community organizations concerned with health.

He lectured at Mills College, Oakland, from 1945-48, and has been a lecturer at the University of California, Berkeley, since 1952.

Dr. Stadel, his wife, and their son and daughter spend much of their leisure time aboard their 45' Alden-designed Staysail schooner. The daughter, a sophomore student at Stanford University, is an avid sailor (with trophies to prove her prowess), skin diver, and sports car racer. The son, a junior high school student, is also an avid skin diver and sailor, but so far has no trophies to his credit.

ACE-HESIVE®

for elastic bandaging that stays in place

B-D

New B-D ACE-HESIVE provides the elasticity and support of famous B-D quality cotton elastic, plus the added strength and holding properties of a specially developed adhesive backing.

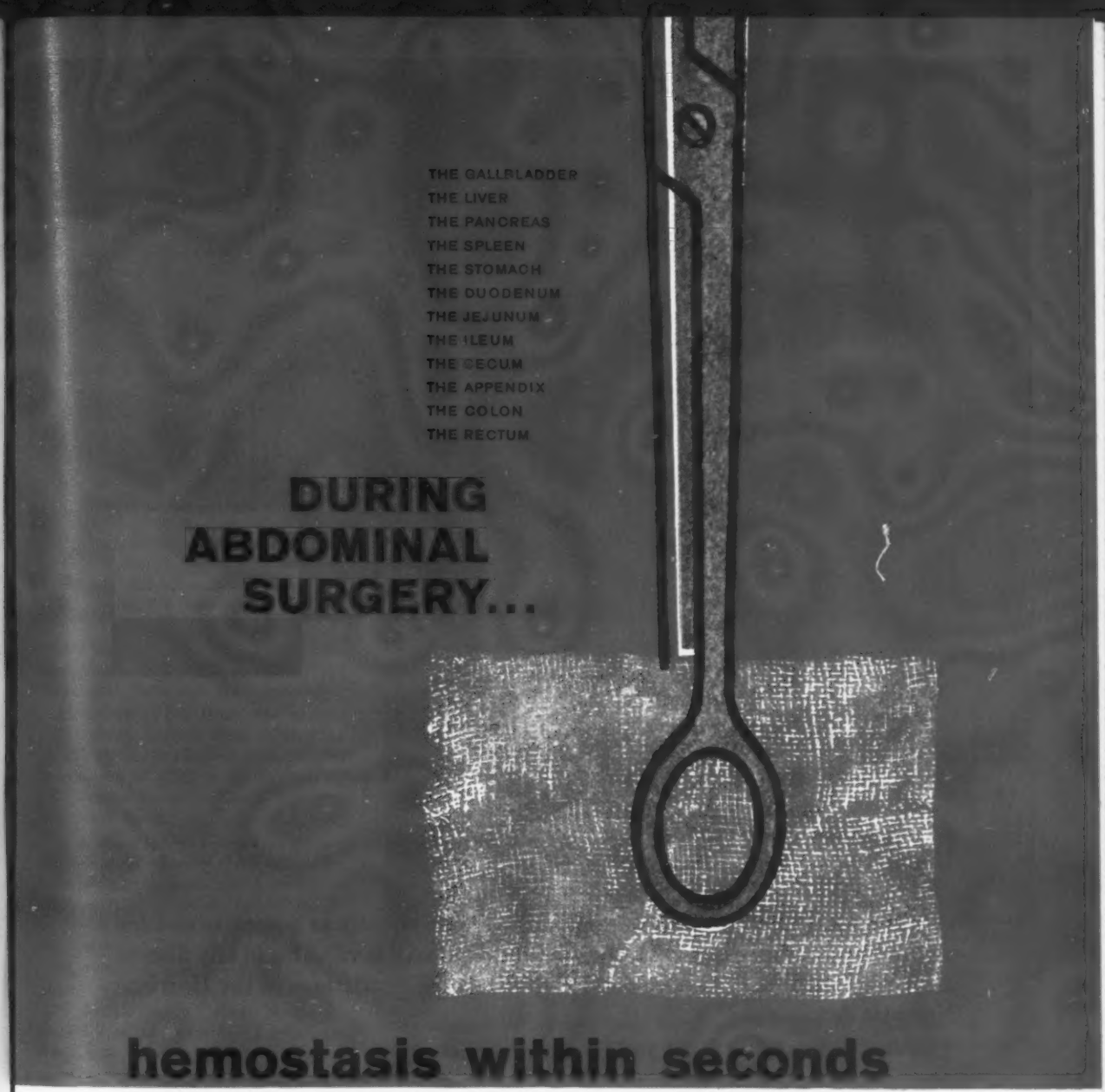
- unfailing support—will not slip or creep, even in hard-to-bandage areas
- sufficient elasticity—correct combination of stretch and tension ensures uniform pressure and ease of application
- minimum skin reaction—purest-grade ingredients practically assure freedom from skin sensitivity
- semipermeable—permits passage of air and excess exudates

ACE-HESIVE hospital package

12 bandages in individual, moisture-proof polyethylene bags, in 2", 2½", 3" and 4" widths.

BECTON, DICKINSON AND COMPANY · RUTHERFORD, NEW JERSEY

B-D AND ACE-HESIVE. T.M. REG. U.S. PAT. OFF. 45057



hemostasis within seconds

THROMBIN TOPICAL

Applied locally to affected surfaces, THROMBIN TOPICAL promptly terminates capillary bleeding. In three seconds, a solution containing 1,000 units per cc. clots ten times its own volume of blood.

THROMBIN TOPICAL is valuable in all surgical operations in which blood seepage from small vessels constitutes a problem. It may be sprayed, flooded or dusted onto tissues.

THROMBIN TOPICAL (bovine origin) is supplied in packages of one vial of 5,000 N. I. H. units with a 5 cc. vial of sterile isotonic saline diluent; in packages of three vials each of 1,000 N.I.H. units with one 6 cc. vial of diluent; and in packages of one vial of 10,000 N.I.H. units.

THROMBIN TOPICAL is intended for topical use only and must never be injected.

MEDICAMENTA VERA PD CO.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

80130

new
non-narcotic analgesic
with the potency of codeine

DARVON

(Dextro Propoxyphene Hydrochloride, Lilly)

is the new, chemically different analgesic which is equally as potent as codeine yet much better tolerated.[1] Orally effective, 'Darvon' is valuable in any disease associated with pain. It does not come within the restrictions of the Harrison Narcotic Act.

'Darvon' is available in 32 and 65-mg. pulvules.

DARVON COMPOUND

(Dextro Propoxyphene and Acetylsalicylic Acid Compound, Lilly)

further increases effectiveness by combining the analgesic action of 'Darvon' with the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound.'*

Each Pulvule 'Darvon Compound' provides:

'Darvon'	32 mg.
Acetophenetidin	162 mg.
'A.S.A.' (Acetylsalicylic Acid, Lilly)	227 mg.
Caffeine	32.4 mg.

Supplied in bottles of 100.

*'*A.S.A. Compound*' (*Acetylsalicylic Acid and Acetophenetidin Compound, Lilly*)

1. *Gruber, C. M., Jr.: J. A. M. A.*, 164:966 (*June 29*), *1957.*

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.

726221

HOSPITAL Topics
The News Magazine for the Hospital Staff

OCTOBER, 1957
VOL. 35, NO. 10

Scanning the News

Develop Common Cold Vaccine At Johns Hopkins

A medical researcher has announced the development of what he considers the first successful vaccine against a major common cold virus.

Winston H. Price, Ph.D., epidemiologist and director, division of medical ecology, school of hygiene and public health, Johns Hopkins University, Baltimore, Md., has isolated the JH virus, named for Johns Hopkins, and perfected a vaccine.

This virus causes 30 percent of common colds. Viruses causing the other 70 percent have not been isolated.

According to Dr. Price, the vaccine will protect against colds caused by the JH virus for eight months. It was successful, he said, in 80 percent of 400 persons inoculated in a series of controlled tests.

In a two-year experimental period, those inoculated were given two shots, a month apart, with no ill effects or discomfort. A third follow-up inoculation is planned which may raise the degree of immunity even higher.

The vaccine was grown in monkey kidney tissue culture and then killed with formaldehyde. Mass production possibilities are considered good, Dr. Price said.

Reports on Medical Problems In Polar Regions

Respiratory ills were the most common medical problem in a scientific expedition on the Greenland Ice Cap, and aspirin the most frequently used medication, Robert W. Christie, M.D., Brookhaven National Laboratory, Upton, N.Y., reports in the *Journal of the American Medical Association.*

In 1955, he and five scientists covered almost 1,200 miles collecting data on bacteriology, physiology, and other sciences. Temperatures ranged between 31° F. and —31° F., and the altitude ranged to 12,000 feet, during the 100-day expedition.

The 61 medical visits were not of a serious nature. Ailments included sinusitis, sore throat, common cold, snow blindness, frostbite, bloody nose, upset stomach, muscle strain, burns, cold sores, and motion sickness. Three members developed diarrhea, and all became anemic despite excellent food.

Dr. Christie recommended inclusion of a qualified physician in Arctic exploratory forces. Injuries usually considered minor become serious in polar regions, where low temperatures, increased altitudes, and lack of external heat complicate injuries, he commented.

Mrs. Janann Koehler Dickey (third from l., front row), Dubuque, Ia., was the happy recipient of a four-year nursing scholarship awarded by the Florist's Telegraph Delivery Association in ceremonies at the Conrad Hilton Hotel, Chicago. Forty-one one-year scholarships were also awarded.

Automotive Parts Used In Medical Pump

A medical instrument to combat edema has been developed by the Ford Motor Co. in cooperation with Henry Ford Hospital, Detroit.

The small, portable, medical pump forces air into a surgical stocking wrapped around the swollen limb, resulting in a rhythmic massage which returns accumulated tissue fluids to the body.

A pressure release valve in the pump is the same one used in Ford passenger-car fuel pumps, and a rubber bellows is the type used in the Ford power-brake system.

New Operation Restores Much of Hearing In Otosclerosis

Hearing lost through poor conduction of sound energy from the vibrating ear drum to nerve endings in the inner ear can be greatly restored by a relatively simple operation, according to its developer, Samuel Rosen, M.D., New York City.

In otosclerosis, the base of the footplate of the stapes is immobilized by newly formed bone growing around it.

Dr. Rosen's method consists either in freeing the stapes, en-

(Continued on page 14)

Why GUDEBROD is your FIRST CHOICE in non-absorbable sutures

. . . because the Cerethermic finish provides superior handling qualities and smoothness, preserves suture strength after repeated sterilization.

. . . because Color-Coding permits positive identification, instant selection of the correct suture size, without error.

. . . because Gudebrod offers a complete line, pre-sterilized or ready for sterilizing, in the most modern, convenient packaging.

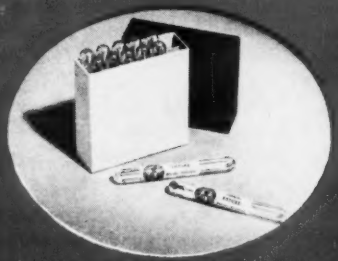
. . . because Gudebrod's unique control of every stage of manufacture, plus 87 years' experience in the suture field, is your assurance of unvarying high quality in non-absorbable sutures.

Specify Gudebrod sutures for the "Champion" in every way.

Dri-Pak ® cut lengths in dry envelopes

Dri-Pak cut lengths in tubes

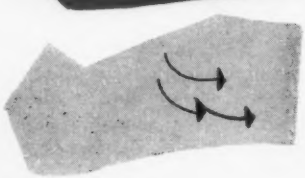
Dri-Pak Ligature Reels in dry envelopes



Tube sutures with Mintraumatic ® needle

Non-sterile on spools or rubber tubes

Dri-Pak in dry envelopes with Mintraumatic needle



Gudebrod

BROS. SILK CO., INC.

Surgical Division: 225 West 34th St., New York 1, N. Y.

Executive Offices: 12 South 12th St., Philadelphia 7, Pa.

Los Angeles
Boston
Chicago

News Briefs at Press Time

SEE POSSIBLE EXPANSION OF SURPLUS COMMODITIES PROGRAM FOR INSTITUTIONS

Expansion of U.S. Department of Agriculture's Surplus Commodities program for institutions seems likely because of increase in surplus supplies.

Foreign countries don't want surplus dumped on them because of effect such a move would have on their economies.

Any supplemental program would probably be based on condition that institutions do not cut down on their present purchases—in other words, aim would be to increase consumption, not to substitute surplus purchases for purchases through regular commercial channels.

Speaking of food, there are indications of a drop in some isolated food prices. Best institutional buy appears to be fowl—particularly turkey, because supply of large birds is so plentiful.

CONSTRUCTION COST SHOULD LEVEL OFF

Cost of construction can be expected to level off for at least the next six months. Apparently effect of increase in concrete costs was not as great as was initially expected. Part of increase has been offset by shipping in larger quantities.

49 REHABILITATION GRANTS APPROVED

Forty-nine rehabilitation projects, in 19 states and the District of Columbia, have been awarded $1,275,789 in grants by the Office of Vocational Rehabilitation.

Projects range from psychologic studies of factors motivating the physically handicapped toward independence to studies aimed at development of rehabilitation procedures for patients suffering from emphysema.

Twenty-eight grants are for new projects; others are for continuations. Among hospital recipients: St. Barnabas, New York City, $44,150; Anderson Orthopedic, Arlington, Va., $37,722, and Vermont State, Waterbury, $30,000.

UMWA SPENDS NEARLY $60 MILLION FOR MEDICAL, HOSPITAL CARE

Expenditures by UMWA Welfare and Retirement Fund for medical care and hospitalization totaled $59,584,594 in fiscal year ended June 30, 1957, according to annual report issued recently.

There were 93,679 beneficiaries, and 1,631,144 days of hospitalization were recorded. Number of participating hospitals: 1,263, in 45 states, Alaska, and District of Columbia.

HOSPITALS PLAY LEADING ROLE IN MEDICAL CARE COST RISE

Hospital costs are the "villain" in the steadily rising medical care cost index, according to the recently issued quarterly index of consumer prices.

When hospital charges and hospitalization insurance premiums are excluded, the increase in medical care costs is pretty much in line with increases in costs of housing, personal care, and miscellaneous goods and services.

This analysis comes as no surprise to hospital administrators, and certainly not to AHA, whose immediate past president, Ray Brown, toured the country during his term of office, discussing problem of sharp rise in hospital costs and the many factors responsible.

BRIEF BRIEFS

Look for legislation to be introduced to provide some kind of financial relief for voluntary public hospitals which obtained RFC loans on condition that they provide special protection and treatment facilities to be available in case of enemy attack . . . Nearly $3 million has been allocated by the Public Health Service among schools of nursing and public health, to support 798 traineeships in 1957-58.

Gordon M. Marshall

Calendar of Meetings

OCTOBER

7- 8 Association of Western Hospitals, Workshop on Admitting Practices, Lafayette Hotel & Lanais, Long Beach, Calif.

7-10 American Academy of Pediatrics, Palmer House, Chicago

7-10 American Hospital Association Institute, Operating Room Administration, President Hotel, Kansas City, Mo.

7-10 American Association of Medical Record Librarians, Schroeder Hotel, Milwaukee, Wis.

8-10 Montana Hospital Association, Northern Hotel, Billings

9-10 Indiana Hospital Association, County Hospital Section, Student Union Building, I.U. Medical Center, Indianapolis

9-11 American Hospital Association Institute, Insurance for Hospitals, Statler Hotel, Hartford, Conn.

This is how I felt Monday mornings before I discovered...

Now...we have Sterilwraps! Monday and everyday my work goes faster and smoother!

STERILWRAPS
FOR WRAPPING PACKS TO BE AUTOCLAVED

Safe, Re-usable, Economical Wrappers
The Nurse's Choice for Hospital Efficiency

STERILWRAPS are suitable for wrapping a wide range of soft goods and instruments, such as Lumbar Puncture Sets (above), Intravenous Sets, Drainage Sets, etc.

Convenient, easy-to-use, always available STERILWRAP Envelopes and Glove Cases insure maximum sterility retention.

Many small articles are conveniently packed in STERILWRAPS—towels, peritoneal packs, cotton, test tubes, throat swabs, culture tubes, syringes, etc.

Convenient: Always ready, even when the laundry and sewing room can't deliver. Take much less space.

Cost less per use than conventional textiles. May be re-used.

A better, safer technique for keeping autoclaved items sterile as long as necessary.

The tensile and wet strength of Sterilwrap's cloth-like crepe is amazing. Won't stiffen or crack; easy to handle.

Use Sterilwrap the same way you use muslin. No change in technique or procedure.

Remember! The initial cost of re-usable Sterilwraps is the complete cost!

Test Sterilwraps yourself

Send today for your FREE SAMPLE TEST KIT, folder and price list. You owe it to yourself and your hospital to use the wrappers that save time, space, money and work.

MEINECKE & COMPANY INC.
Serving The Hospitals Of America For More Than Sixty Years

225 Varick St., New York 14 ● 736 E. Washington Blvd., Los Angeles 21, Calif.
9012 Sovereign Row, Dallas 19, Texas ● 419 Gadsden St., Columbia, S. C.

9-11 Mississippi Hospital Association, Hotel Buena Vista, Biloxi, Miss.

10-11 Colorado Hospital Association, Hotel Denver, Glenwood Springs, Colo.

13-18 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

14-18 American Society of Anesthesiologists, Statler Hotel, Los Angeles

14-18 American College of Surgeons Clinical Congress, Convention Hall, Atlantic City, N. J.

14-18 American Hospital Association Institute, Methods Improvement Workshop, Bon-Air Hotel, Augusta, Ga.

14-25 Workshop, Operating Room Nursing, University of Kansas Medical Center, Kansas City

15-16 South Dakota Hospital Association, Sheraton Cataract Hotel, Sioux Falls, S. D.

17-18 American Hospital Association Institute, Operating Problems for Small Hospitals, Regina City Museum, Regina, Saskatchewan, Can.

17-18 Nebraska Hospital Association, Cornhusker Hotel, Lincoln

17-18 New England Hospital Assembly, Instructional Conferences, Hotel Statler, Boston

18 Vermont Hospital Association, Long Trail Lodge, Pico Peak, Rutland

20-26 American College of Gastroenterology, Hotel Somerset, Boston

21-23 American Hospital Association Institute, Medical Record Library Personnel, Hilton Hotel, Albuquerque, N.M.

21-22 Idaho Hospital Association, Hotel Boise, Boise

21-25 National Safety Council, Conrad Hilton Hotel, Chicago

22-25 American Dietetic Association, Dinner Key Auditorium, Miami, Fla.

23-25 Florida Hospital Association, Institute on Hospital Accounting, Monte Carlo Hotel, Miami Beach

26 American College of Osteopathic Hospital Administrators, St. Louis, Mo.

26-30 American Heart Association, Sherman Hotel, Chicago

28-30 Association of Military Surgeons of the U. S., Hotel Statler, Washington, D. C.

27-30 American Osteopathic Hospital Association, St. Louis, Mo.

(*Continued on page 12*)

Bactericidal! Fungicidal!

DERMOPLAST® aerosol

TOPICAL ANESTHETIC • ANTIPRURITIC • ASTRINGENT

IN OBS & GYN USE

NEW—3 OZ.
PRESCRIPTION SIZE

for individual therapy in hospital and home.

Also available in . . .
HOSPITAL economy size .... 12 oz.
JUNIOR size ..... 6 oz.

PROVIDES NEW RELIEF OF SURFACE PAIN AND ITCHING
ON CONTACT WITHOUT TOUCHING AFFECTED AREAS

perineal suturing
hemorrhoids
pruritus ani
pruritus vulvae
wounds
burns
abrasions
sunburn

FORMULA: benzocaine 4.7%; benzethonium chloride 0.1%; menthol 0.5%; dissolved in oils (Doho process)

Substantiating clinical data sent on request

MALLON DIVISION
DOHO
100 VARICK ST.
NEW YORK 13, N. Y.

CALENDAR OF COMING EVENTS

(Continued from page 10)

27-31 American College of Osteopathic Surgeons, Jefferson Hotel, St. Louis, Mo.

28-30 Ontario Hospital Association, Royal York Hotel, Toronto, Can.

28-Nov. 1 American Hospital Association, Institute on Evening and Night Nursing Service, Mission Inn, Riverside, Calif.

30-Nov. 1 California Hospital Association, Lafayette Hotel, Long Beach

30- Nov. 2 National Society for Crippled Children and Adults, Annual Convention, Palmer House, Chicago

31-Nov. 2 Missouri Hospital Association, Hotel Jefferson, St. Louis

NOVEMBER

4- 5 Oregon Association of Hospitals, Eugene Hotel, Eugene

4- 6 American Association of Blood Banks, Hotel Sherman, Chicago

4- 8 American Association of Inhalation Therapists, Hollender Hotel, Cleveland, O.

6- 7 Washington State Hospital Association, Olympic Hotel, Seattle

6- 8 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D.C.

7- 8 Oklahoma Hospital Association, Mayo Hotel, Tulsa

11 American Hospital Association Institute, Housekeeping, King Edward Hotel, Toronto, Can.

11 American Hospital Association Institute, Medical Record Library Personnel, Sheraton-Plaza Hotel, Boston, Mass.

11 American Hospital Association Institute, Nursing Service Administration, Princess Kaiulani Hotel, Honolulu, Hawaii

11-15 American Public Health Association, Auditorium, Cleveland, O.

13 Connecticut Hospital Association, Conn. Light & Power Co., Berlin

14-15 Kansas Hospital Association, Broadview Hotel, Wichita

14-22 Seventh Congress, Pan-Pacific Surgical Association, American Hospital Association Institute, Honolulu, Hawaii

14-16 Virginia Hospital Association, Hotel Chamberlin, Old Point Comfort

17-22 Radiological Society of North America, Palmer House, Chicago

18-22 Pan American Medical Association, Mexico City, Mexico

18-22 American College of Hospital Administrators, New England Institute, Somerset Hotel, Boston

18-22 American Hospital Association Workshop on Operating Problems for Small Hospitals, Texas; Amarillo, 18; Abilene, 19; Dallas, 20; College Station, 21; Corpus Christi, 22.

21-23 National Association for Mental Health, Annual Meeting, Shelbourne and Dennis Hotels, Atlantic City, N. J.

DECEMBER

2- 6 American College of Hospital Administrators, Advanced Institute, Ambassador Hotel, Los Angeles

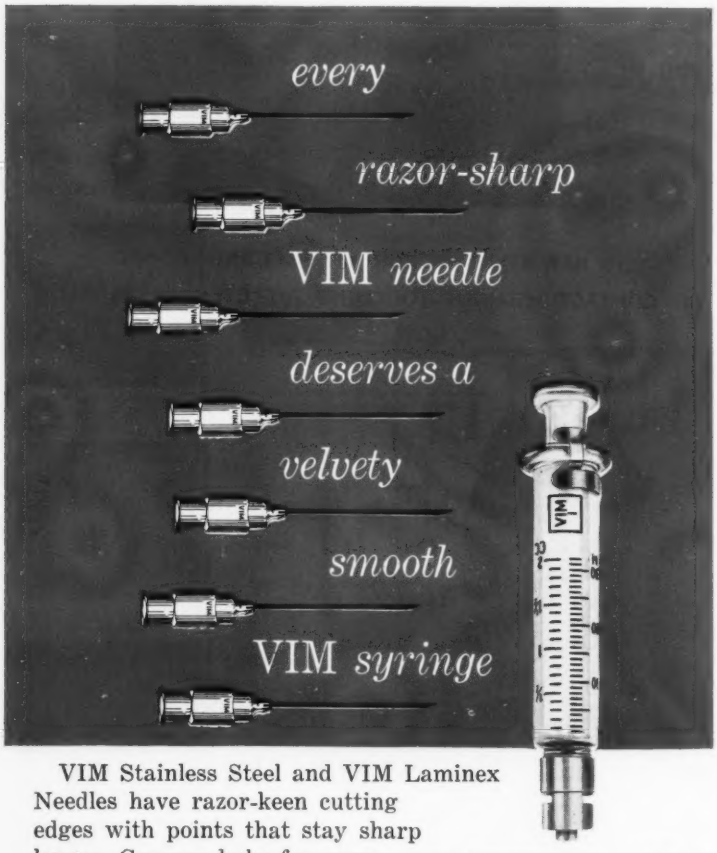
3- 6 American Medical Association (Clinical Meeting), Commercial Museum, Philadelphia

5- 6 Illinois Hospital Association, Hotel Abraham Lincoln, Springfield

5- 6 Arizona Hospital Association, Hotel Westward Ho, Phoenix

7-12 American Academy of Dermatology and Syphilology, Palmer House, Chicago

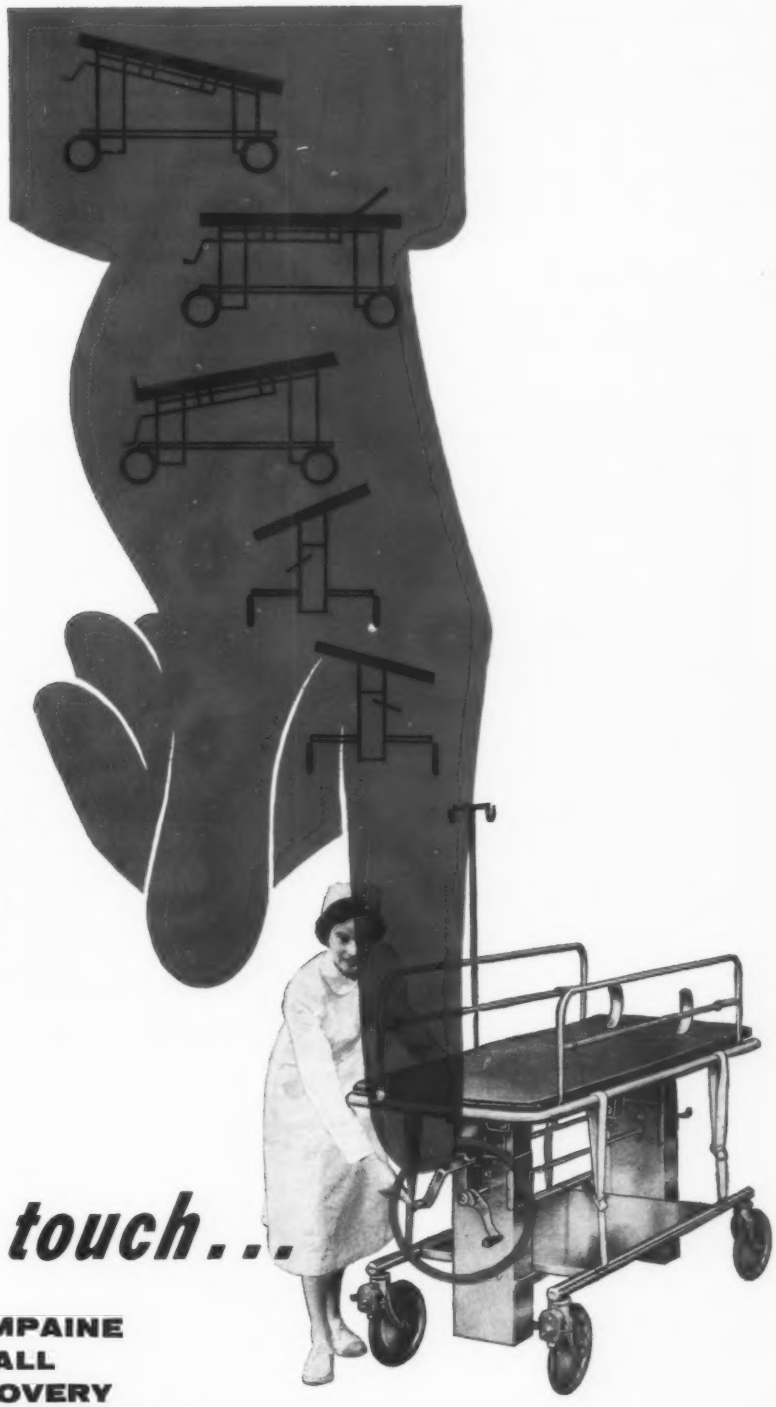
(Continued on page 14)



VIM Stainless Steel and VIM Laminex Needles have razor-keen cutting edges with points that stay sharp longer. Concave hubs for easy handling. All VIM Syringes, including stronger clear-glass VIM Interchangeable Syringes (any plunger fits any barrel), have a velvety-smooth action, free from backfire and leakage.

VIM®
hypodermic needles and syringes

For further information, consult your hospital/surgical supply dealer or write:
MACGREGOR INSTRUMENT COMPANY, NEEDHAM HGTS., MASSACHUSETTS



Single-end controls for all positions.

One attendant easily transfers a patient even in congested rooms . . . a real boon to understaffed and crowded hospitals! No lifting or excessive patient handling.

tilts at a touch . . .

SHAMPAINE
TRANS-ALL
RECOVERY
STRETCHER

the world's most complete line of physicians' and hospital equipment

Shampaine COMPANY

1920 S. Jefferson, St. Louis, Missouri

CALENDAR OF COMING EVENTS
(Continued from page 12)

26-31 American Association for Advancement of Science, Murat Temple, Indianapolis, Ind.

JANUARY 1958

20-24 Southern American College of Hospital Administrators Institute, Jackson, Miss.

23-24 Alabama Hospital Association, Hotel Stafford, Tuscaloosa

FEBRUARY 1958

10-13 Association of Operating Room Nurses, Bellevue-Stratford Hotel, Philadelphia

11-13 National Association of Methodist Hospitals and Homes, Morrison Hotel, Chicago

13-17 Follows Seminar, American College of Hospital Administrators Institute, University of North Carolina, Chapel Hill

SCANNING THE NEWS
(Continued from page 7)

abling it to vibrate, or in cutting a window through the base of the stapes and into the inner ear.

About 300 of the window-making operations have been performed, Dr. Rosen reports, with "significant improvement" in 72 percent of those who had good bone conduction except for the frozen stapes.

"No wonder it's the best!"
SPECIAL FORMULA FOR HOSPITAL USE
WECK CLEANER
for SURGICAL INSTRUMENTS • CATHETERS • SYRINGES
RUBBER GLOVES • TUBING • LABORATORY GLASSWARE
NET WEIGHT: 5 POUNDS
EDWARD WECK & CO., INC.
the ONLY INSTRUMENT CLEANER made by an INSTRUMENT MANUFACTURER
Goes Twice as Far!
½ oz.—instead of the usual one oz.—to the gallon! One 5 lb. can makes 160 gallons of cleaning solution. This by actual hospital test is enough to clean 36,000 instruments or all the instruments needed in 565 average operations! An entire laparatomy instrument set costs less than 1¢ to clean with this "miracle" cleaner!
• Removes clotted blood and other contamination rapidly.
• Cleans effectively even in the hardest water.
• Wets, penetrates, dislodges and emulsifies all soils rapidly.
• Dissolves rapidly in warm water.
• Does not produce foam which would interfere with mechanical washing.
• Does not corrode metal or etch glass.
• Completely safe to use. Does not contain free caustic. No more alkaline than a neutral soap.
PRICES PER 5 LB. CAN WITH MEASURING SPOON:
1 can $5.20
3 cans 5.00 each
6 cans 4.80 each
12 cans 4.60 each
36 cans 4.40 each
FREE SAMPLE! Simply mail a post card marked "Free Sample of Weck Cleaner" with your name and address. With the generous sample you will receive complete instructions on the most effective way—the WECK way—to clean surgical instruments, catheters, syringes, rubber gloves, tubing, laboratory glassware, etc.
67 Years of Knowing How
EDWARD WECK & CO., INC. 135 Johnson St., Brooklyn 1, N.Y.
MANUFACTURERS OF SURGICAL INSTRUMENTS • HOSPITAL SUPPLIES • INSTRUMENT REPAIRING

Mosquitoes Have Large Blood Capacity

Two scientists report that 95 mosquitoes can drink one quart of blood in a day.

Fifty blood-gorged mosquitoes were caught and killed. They outweighed their fellow creatures almost four to one. It requires 95 mosquitoes per minute to withdraw one quart of blood per day.

R. E. Monroe, Oregon State College, and R. A. Hoffman, U.S. Department of Agriculture at Stoneville, Miss., figured it would require a feeding rate of 95 mosquitoes per minute to withdraw one quart of blood per day.

Child's Personality Based On Physique

Children have personalities based upon body builds, according to three Oxford doctors.

Tests were made on 100 seven-year-old children. Thin, bony children were far better readers than plump, jolly youngsters. Children with practical minds were both muscular and aggressive.

Anxiety and "showing off" were most frequent with boys having less than average muscle. Fatter boys displayed both confidence in themselves and in life.

Slender boys appeared to be less affectionate than those of bigger build. The friendliest girls were the tubbiest. Slender girls were meticulous and adopted a defensive attitude toward life.

Instrument Measures Body Radioactivity

A total body radioactivity counter has been designed and developed by Gerald J. Hine, Ph.D., radioisotope service physicist, VA Hospital, Boston.

According to Dr. Hine, the counter marks a "break through existing limits of radiation detection," and is the only one of its type in U.S. hospitals.

The instrument is so sensitive it can measure and identify tiny amounts of radioactivity naturally present in the human body.

DEPENDABLE

Make this simple test!
Prove to yourself that the

DEKNATEL PLASTIC PAK will not leak!

- **HERMETICALLY SEALED—NO LEAKAGE**

  Squeeze a Deknatel Pak with all the strength of your fingers. The seal will *not* break. Actually, every Deknatel Plastic Pak is tested for leakage by a pressure markedly exceeding all practical requirements.

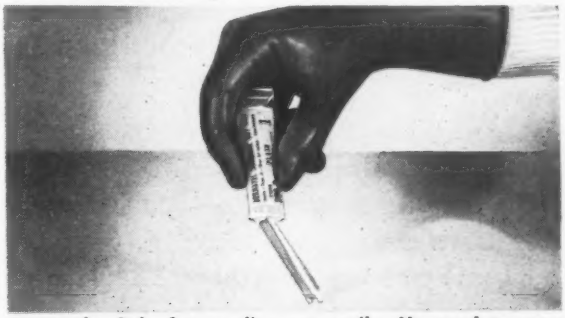
- **STERILITY TECHNIQUE UNCHANGED**

  You sterilize in formaldehyde, just as you have always done with glass tubes.

  Suture handling is reduced to the minimum as illustrated at the right.

For samples of the new Deknatel Plastic Pak, write to J. A. Deknatel & Son, Inc., Queens Village 29, New York.

Just cut straight across. Pak is transparent . . . no special care needed in cutting.



Invert the Pak. Suture slips out easily. No need to use fingers or forceps.

DEKNATEL
PLASTIC PAK
—No Glass to Break—

SAVE TIME by Using This Gilbert Type BARDEX® FOLEY CATHETER

with Self-Sealing Plug in Inflation Funnel

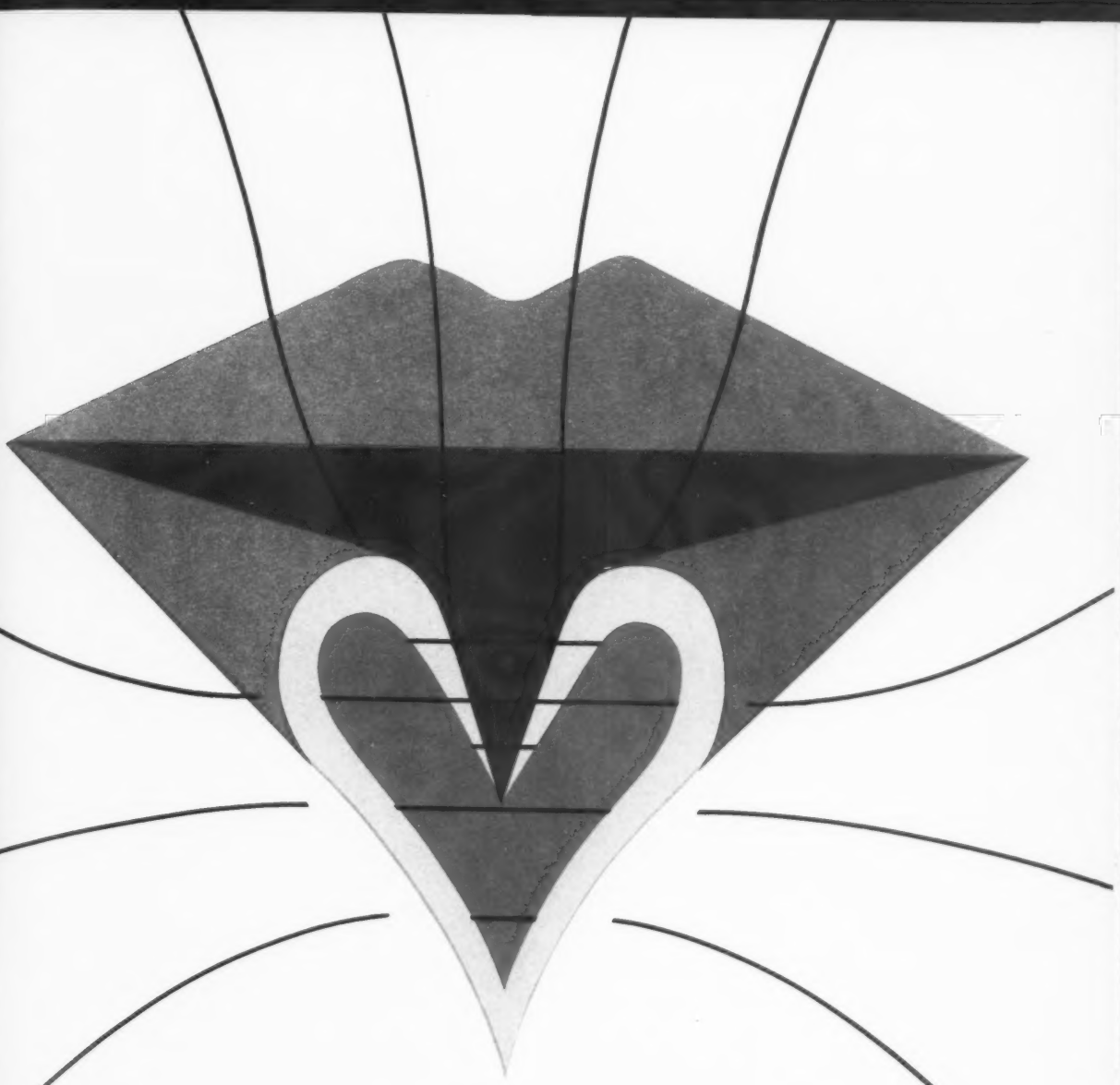
ONE PERSON can easily inflate and deflate this Gilbert type BARDEX Foley Catheter. No assistant is needed to clamp or tie off the inflation funnel.

Using a syringe with a 1 inch 20 gauge needle, the plug is easily punctured. Then the balloon is inflated to the exact size desired with a measured amount of water.

When the needle is withdrawn, the plug is self-sealing. There is no drip after inflation or deflation. To deflate, merely puncture plug with needle on empty syringe.

More and more hospitals and physicians are saving time and money by using this Gilbert Type BARDEX Foley Catheter.

C. R. BARD, INC.
SUMMIT, NEW JERSEY



setting new standards

ETHICON®

sutures

TRU-PERMANIZED surgical silk

superior handling qualities – greater tensile strength

ETHICON®

A

S

D

IC

Ne
Cu

Hel
Pair

A n
elim
tech

T
scal
with
has
If t
poos
rubb

O
tient
go.
dow
coml

A
to h
close
of le
surg

Cl
of th
to cu
neces
is co

Below
Hospi
I. Be
Califo

Anesthetic, Open Cardiac Surgery, Harelip Discussed at ICS Conclave

Above: Ross T. McIntire, M.D., co-chairman, Twenty-Second Annual Congress, International College of Surgeons, takes a minute from his busy schedule to talk to R. N. Calvert, M.D. (r.), surgical staff, Washington Sanitarian Hospital, Silver Springs, Md.

New "Shampoo" Eliminates Need for Cutting Woman's Hair in Brain Surgery

Helps Overcome Psychological Pain Associated With Procedure

A new technic for brain surgery has been developed which eliminates the need for cutting a woman's hair. The technic overcomes a serious psychological problem.

The patient is instructed to shampoo her hair and scalp five times—preferably once a day for five days—with a special surgical detergent to which hexachlorophene has been added. This kills all germs present in the scalp. If time does not permit the five-day procedure, she shampoos twice a day. She is told to use the same bobby pins, rubber bands, and comb each time.

On the day of the operation, the surgeon uses the patient's comb to part the hair just where the incision should go. Another antiseptic solution is used to wet the hair down and comb it out of the way on either side of the comb.

A wave-setting compound in an aerosol bomb is sprayed to hold the hair in place. Surgical towels are fastened as close to the part as possible, leaving a total exposed area of less than three-quarters of an inch in diameter. The surgeon then makes his incision in the usual fashion.

Closing of the wound is accomplished by tying the ends of the stitches over a gauze roll. The roll, which is made to curve over and lie on the incision, is the only dressing necessary. Several days later the stiffening preparation is combed out of the hair.

Below: L. F. Livisay, M.D., assistant visiting obstetrician, Harlam Hospital, New York City, discusses the morning session with Robin I. Bennett, M.D., staff member, Alta Vista Hospital, Pasadena, California.

This procedure has been used in 20 operations without a single infection.—**Jonathan M. Williams,** Assistant Clinical Professor of Neurosurgery, George Washington School of Medicine, Washington, D. C.

New Anesthetic Kills Pain Prior to Surgery

Vitamin Derivative Does Not Depress Breathing Rate

SCTZ, a sleep-producing drug derived from vitamin B-1, produces loss of consciousness without anesthesia or analgesia.

It is a sedative and hypnotic—not a neuroleptic, since it does not act on the autonomic nervous system.

In a study of 80 subjects, we found that profound sleep of 10 to 20 minutes duration could be induced rapidly by intravenous injection of 1.2 gr. (three ampules of 20 cc.) of two percent solution.

Sleep was maintained by a slow, continuous intravenous drip. Regardless of the depth of sleep, the patient reacted to all stimulation without regaining consciousness and remained amnesic.

Respiration was never depressed by the dosage used, but was occasionally stimulated, with increase in amplitude and frequency.

No electrocardiographic disturbance was observed. When the injection was given rapidly, there was frequently a distinct but brief acceleration of the cardiac rate.

Defense reactions are controlled by using curare. Then a true anesthesia without anesthetic is produced.

Preliminary studies indicate the drug will play an important part in childbirth because it alleviates pain without harming the fetus.—**Henri Laborit, M.D.,** Director, Experimental and Clinical Research on Artificial Hibernation, Army Research Center, General Military Hospital, Paris, France.

Technic Extends Time for Heart Stoppage Under Hypothermia

Selective Cooling Lowers Brain Temperature to 65°F.

Selective cooling of the brain by irrigation has made it possible to stop the heart for 15 minutes when hypothermia is being used for open heart surgery.

Previously, eight minutes has been considered the maximum safe limit for cessation of circulation under general hypothermia.

(Continued on next page)

Above: C. R. Hancock, M.D. (l.), attending staff, Red Deer Municipal Hospital, Alberta, Canada, and Eugene Balanserc, M.D., attending staff, St. Joan of Arc, Montreal, Canada, meet in the Canadian hospitality booth for coffee.

Above: Sister M. Ethelburga, R.N. (r.), surgical supervisor, and Sister M. Fortunata, R.N., central supply supervisor, both of St. Francis Hospital, Peoria, Ill., check the program for the location of the next session.

In our method, the brain temperature can be lowered to 65° F. or less while a rectal temperature of about 90° is maintained.

The technic was first applied in July, 1955, to a 10-year-old girl suffering from a defect in the atrium. Her general body temperature was partially lowered with the administration of a combination of drugs, or "lytic cocktail."

The further reduction in the brain temperature was obtained by inserting two polyethylene tubes in the common carotid artery, which supplies the head and brain. The blood was sidetracked through the tubes, cooled, and pumped back into circulation in the head. The brain temperature was reduced to 65.4°, while the rectal temperature was held at 90.5°.

Irrigation was stopped and the head surrounded by ice bags to avoid an excessive rise of temperature. Four minutes later, the flow of blood into the heart was stopped and the heart contents emptied. Surgery was then performed with the lesions in full view.

The open cardiac procedures required circulatory cessation for 14 minutes and 20 seconds. Ventricular fibrillation and dangerous cardiac beat did not occur. Spontaneous respiration was seen just after release. After the incision was closed, the patient was placed in a hot bath until the rectal temperature rose to 95.2°.

The second and third cases underwent similar courses. We believe that the technic could be applied with good results to corrections of irregularities in the upper chambers of the heart.—**Kazumi Taguchi, M.D.**, Assistant Professor of Surgery and Chief, Cardiac Division, Okayama University Medical School, Okayama-shi, Japan.

Replaced Heart in Dog Beats for Two Hours

Done Without Aid of Mechanical Device

A heart transplanted from one dog to another has been kept alive and beating for approximately two hours without the aid of any mechanical device.

The circulation of the recipient was maintained by a pump oxygenator while the donor's heart was anastomosed to the recipient's vessels. Then the perfusion by the oxygenator was withdrawn.

In the first experiment, the heart beat well and maintained the circulation of the dog at a rate of 90 beats per minute for 21 minutes before suddenly developing ventricular fibrillation. A defibrillating apparatus was not available.

In the second experiment, the replaced heart maintained the circulation for one hour and 57 minutes. It then developed ventricular fibrillation, followed by standstill. Heart action was stimulated by an artificial pacemaker. Normal sinus rhythm persisted for five to 10 minutes, and standstill recurred. This cycle of events continued, the pacemaker being applied intermittently, until the experiment was purposefully terminated.

An active acquired tolerance may be produced in a host which will cause the rejection of homografted tissue. Biologists seem on the threshold of solving the immunologic barrier to permanent tolerance to transplanted organs.

Since it has now been shown that the circulation of the body can be resumed with a transplanted heart, future efforts must be directed toward assuring the constancy of success in the transfer.—**Edgar F. Berman, M.D., Mauricio Goldberg, M.D.**, and **Leonard Akman, M.D.**, Sinai Hospital, Baltimore, Md.

Vitamins Given Mothers in Attempt To Prevent Cleft Lip, Palate

Deformities Produced in Mice By Injections of Cortisone

Vitamin B_6 and folic acid are being given routinely, early in pregnancy, to pregnant women who have had a cleft palate or cleft-palate child, in an effort to prevent these deformities in the unborn children.

We adopted this practice as a result of laboratory experiments on mice which showed that injections of cortisone acetate, given in four daily doses just before the normal fusion of the embryonic palate, resulted in 85 percent cleft palates in full-term embryos of the Swiss albino strain.

Concurrent injection of vitamin B_6 reduced the incidence to 45 percent. A combination of cortisone acetate and folic acid yielded 20 percent of cleft palates among the full-term offspring. About the same results were obtained

Laura Jackson, congress manager, International College of Surgeons, puts up a message on the board. At the convocation Miss Jackson was awarded honorary membership in ICS.

E. P. Coleman, M.D., chief of staff, Graham Hospital, Canton, Ill., views an exhibit on experimental liver surgery and stops to leave his name for reprints of the exhibit.

with the combined use of cortisone acetate, folic acid, and vitamin B_6.

All children born of patients who have received the vitamin therapy have been normal, but the series is not large enough to be significant.

Stress may be a factor in producing congenital abnormalities in humans, although we were unable to produce this with mice. The theory is that emotional or other forms of stress in pregnant mothers induces the production of ACTH, which stimulates an excess of adrenal cortisone, and that this excess during the early period of pregnancy—critical for the development of the palate—inhibits fusion of the palatal shelves.

In questioning mothers with cleft-palate or cleft-lip children, we have found, in a preliminary analysis, a rather high incidence of emotional disturbances, but the information has not yet been compared to statistics on the incidence of such disturbances in mothers giving birth to normal children.—**Lyndon A. Peer, M.D.**, Chief, Department of Plastic Surgery, St. Barnabas Hospital for Women and Children, Newark, N. J.

Surgery Performed on Infants With Pulmonary Cysts

Thoracotomy Indicated When First Symptom Occurs

Three infants having pulmonary cysts have been operated on successfully. One of them was 19 days old with asphyxia and cyanosis. The other two suffered from respiratory difficulty and repeated infection. One was five months old and the other 10 months.

Thoracotomy is indicated as soon as the first symptom occurs. In every case of respiratory distress in infants, and with repeated infections, the possibility of a cyst should not be overlooked. X-ray studies should be made. —**Juan Netto, M.D.**, Professor of Clinical Surgery, Faculty of Medicine of Asuncion, Paraguay.

Cardioscopes Aid Observation Of Interior of Heart

Films Taken Through Instrument Help Indicate Surgery Needed

We are using two types of cardioscopes to reveal irregularities of the heart in action. One is a tube with a rubber balloon fixed at its tip. Saline solution is injected through the tube, and the balloon can be inflated to any desired size. Elasticity makes it possible to keep contact with the wall and valves, permitting close observation. The tip also has outlets for saline solution to dilute the blood in areas not in contact with the balloon.

The second type, constructed for operative use, has a cap of vinyl chloride, which, when warmed to body temperature, becomes exceedingly pliable and adheres closely to the heart wall.

Adequate observation of the interior of the heart can be carried out without producing any change in cardiac activity. Motion pictures can be taken through the cardioscope which show heart valves in action and indicate the type of operation which should be done to correct defects.

We have developed a safe method of valvotomy with the cardioscope. The instrument also permits safer and more exacting operations in cases of aortic stenosis.—**Shigeru Sakakibara, M.D.**, Professor of Surgery, Tokyo Women's Medical College, Tokyo, Japan.

Hazards of Skin Diving Told By Navy Medical Officer

Inability to Equalize Pressure May Cause Damage to Ears, Sinuses

With the increased popularity of skin diving by amateurs, physicians can expect to encounter more conditions and injuries resulting from exposure to increased atmospheric pressures.

The medical problems can be divided into three categories: those occurring during the descent or compression phase, those occurring on the bottom, and those occurring during the ascent or decompression.

The inability to equalize pressure during descent can result in considerable damage to the ears and sinuses. Air-containing structures attached to the body, such as goggles, which have no means of pressure equalization, may act as suction cups on excessive descents and cause injuries.

While the diver is disporting himself on the bottom, nitrogen is being dissolved in his body fluids and tissues, creating a condition similar to a carbonated soft drink, without the benefit of a cap to keep the nitrogen from "bubbling" when the pressure is released. Too rapid ascent from a deep dive may cause compressed air illness, or the "bends." **Capt. Gerald J. Duffner**, Medical Officer, Experimental Diving Unit, Naval Gun Factory, Washington, D. C.

Left: Talking in the registration area before the technical exhibits opened were Herbert L. Crowley, Jr., (l.), Crowley & Gardner Co., immediate past president, and Louis Karel, Karel First Aid Supply Co.

Sales Clinics, Exhibits Attract ASTA Members

● Sales-service clinics and technical exhibits attracted 1,764 to Chicago's Hotel Sherman in August for the annual American Surgical Trade Association meeting.

Visitors to the 164 booths in every nook of the wandering exhibit hall saw everything from home stairway elevators and a new oxygen tent especially engineered for high humidity medication, to nonbreakable nylon connectors and a noiseless multi-height bed.

A total of 91 sales-service clinics were held by 51 separate companies. The hour-long sessions were held concurrently the last two days of the convention, after the technical exhibits were closed. Some participating manufacturers placed emphasis on repair and maintenance of equipment, while others provided sales information. Each company was permitted to discuss in detail the advantages of individual products or brands. One or more of the sessions were attended by 192 dealer salesmen.

Donn Mason, Donn Mason Co., spoke on a "Do-It-Yourself Sales Training Kit" at a group luncheon for members and manufacturers. Larkin Edmondson, Durr Surgical Supply Co., was moderator at a sales training program for surgical supply distributors. Speakers included Jim Taylor, Cary-Taylor Corp.; Larry Donovan, E. F. Mahady Co., and Lou Markle, Medical Arts Supply Co.

Members participating in a statistical survey attended concurrent management seminars and listened to R. N. Yeates, General Surgical Supply; Ray Goff, Massey Surgical Supply Co.; Rufus Smith, Crocker-Fels Co., and T. H. Tomlinson, Carolina Surgical Supply.

Also on the agenda was the president's wife's tea, annual banquet, and a sales-service clinic group luncheon, at which William H. Gove, E.M.C. Recordings Corp., told members, "You Make the Difference."

Right: Part of group attending Hyland Laboratories' sales-service clinic listen attentively to speaker. Chart in background illustrates department to contact and what to sell.

Pictured at the banquet are Mr. and Mrs. Dale Deckert, Deckert Surgical Co. Mr. Deckert is the new president. Other officers are: Harold L. Larson, Kreiser Surgical, Inc., president-elect; Walter D. Davis, Durr Surgical Supply Co., vice-president; Frank M. Rhatigan, secretary, and C. Richard Lovelace, Murray-Baumgartner Surgical Instrument Co., Inc., treasurer.

Enjoying the annual banquet were Mr. and Mrs. Mack Fullton, Winchester Ritch Surgical Instrument Co., and C. Richard Lovelace, Murray-Baumgartner Surgical Instrument Co., Inc., treasurer. Mr. Fullton is director, region 11.

For a pictorial coverage of new products shown at the ASTA convention, turn to pages 74 through 81.

Right: Frank M. Rhatigan, secretary, presents camera to Herb Crowley, outgoing president.

Above: Pictured in lobby are Harold L. Larson, Kreiser Surgical, Inc., president-elect, and Gil Straus, Glendale Surgical Supply Co., director, region V.

Below: Participants in Universal Sterilizer's sales-service clinic examine one of the company's products.

Fire Prevention Program For Los Angeles Hospitals

THE total fire-safety program for hospitals within the city limits of Los Angeles is built around four factors which each year cause major fire losses throughout the United States. These are:

1. Structural deficiency of buildings
2. Delayed discovery of fires
3. Flammable contents of buildings
4. The human element.

Design defects in buildings are not new discoveries. They have cropped up in fire reports for many years, yet the same mistakes continue to be made year after year, even though it should be realized that it is just as important for structures to be designed to resist and control fires as to withstand gravity loads. With this ever-present problem in mind, we have, in our Fire Prevention Bureau, an engineering and research unit which checks plans and blueprints for new buildings and additions to existing buildings.

Most persons assume that a fireproof building is the answer to the fire problem. Fireproof buildings and fire-safe buildings are totally different structures. Contents of buildings can easily cause sufficient smoke to kill occupants just as quickly in a so-called fireproof building as in any other. In fact, the very tightness of some modern buildings creates a greater life-safety hazard.

Buildings should be designed with the idea of safely caring for the gases of combustion which are developed in fires. This principle applies not only to multi-story buildings but to all structures.

More lives are lost from fire gases than from fire itself. When these gases are formed, there is a tremendous expansion. One pound of wood will create about three cubic feet of gas. Treated or painted wood increases the amount of gas formed. This gas must go somewhere. If it cannot get out, it will rise and mushroom, gaining more and more pressure which enables it to push into all areas of a building. It is this fire gas, spreading through buildings, that kills so many people. In the LaSalle Hotel fire, in Chicago, 61 persons died—every one from fire gases—untouched by the fire itself.

Because less wood is being used in buildings, we may think we are safe, but, at the same time, fiberboard is substituted for ceilings and walls; combustible acoustic materials are used in air ducts; fabrics which are not flameproofed are used for draperies, and non-fire-resistant paints are still used.

Our engineering and research unit recommends methods of properly venting buildings, dividing areas into smaller fire-safe sections, reducing the hazards of air-conditioning systems, developing adequate exits and stairways, eliminating concealed spaces where fires may reach large proportions before they are discovered, and installing automatic sprinkler systems.

The automatic sprinkler system is still the greatest enemy of fire at our command. We realize that, in many cases, an installation of sprinklers can be very costly. However, management often has been able to pay for a sprinkler system through the savings effected in fire-insurance premiums.

Recent developments in fire protection have given us electronic signaling devices which will detect smoke, sound an alarm, and operate fire-extinguishing systems. These new devices will help eliminate delayed discovery of fires.

Beyond attempting to build more fire safety into buildings, we have a corps of specially trained men who make thorough routine inspections of all hospitals and institutions in the city. These inspections are aimed at reducing the fire hazards present in the contents and processes within the buildings.

The three articles in this series, written by Inspectors Ed Meyer and Joe Corbett of our plant protection unit cover the last portion of our total fire-safety program—the human element.

Benjamin F. Renfro
Fire Prevention Engineer
Education Section
Los Angeles Fire Department

Safeguard Lives, Notify Fire Department

● Education, together with enforcement, has for many years been the aim of the Los Angeles Fire Prevention Bureau. This most certainly applies to fire safety of hospitals and similar institutions.

The institutional fire safety program used in the City of Los Angeles has been developed with the thought of making it a complete fire-safety effort. It is, however, flexible enough to be adapted to any institution, no matter how large or small—how simple or complex.

The program's main objectives are to make an institution as fire-safe as possible, and, in the event of fire, to reduce the loss of human life and property to the absolute minimum.

To put into effect this type of program, it is essential that top-level management be aware of the need and recognize the importance of the program. Management must desire such a program; must encourage it, support it, and participate in it.

Before the Fire Department starts any actual training, institutional management prepares certain educational and training aids, with the department's assistance. Usually a management safety committee (made up of several department heads) meets with the Fire Department representative to develop the program's working tools. The program, started with a basic plan, is actually tailored to fit the individual hospital by the people who know it and

its problems best. This joint development procedure assures full cooperation of all parties concerned.

The aids developed are:

1. **Notice to all employees.** This is simply an official notice, signed by the administrator, informing the employees that a fire-safety program will be started in the very near future; that management wants the program; that each employee has certain responsibilities in it and will be required to do his part to make it successful. See Figure 1.

SUGGESTED NOTICE TO ALL EMPLOYEES

To All Employees:

Should fire or disaster occur in this hospital, the life and safety of patients and other employees may depend directly upon YOU.

The management of ..... Hospital will, in the very near future, begin a "Hospital Fire Safety Program" for the protection of life and property on these premises.

YOU can take an active part by knowing how to report a fire or emergency immediately, as follows:

1. Remove any person from room and close the door to confine the fire.

2. Operate the fire alarm on the wall. THEN call the hospital telephone operator and tell her where the fire is located.

3. Return to fire and use fire hose or extinguisher.

All persons employed in the ..... Hospital are required to comply with the above procedure.

Figure 1

2. **Organizational chart.** The organizational chart is important because it outlines everyone's position in the program. Once it becomes a part of the booklet, it is always there for immediate referral.

FIRE *(in red)*

Method of Procedure

REPORT ALL FIRES! *(in red)*

Keep Calm!

1. Safety of life
   If fire is in patient's room—remove patient.
   Close the door, windows, transoms.
2. Go to nearest telephone—dial _____
   Tell Fire Department this address _____
3. Return to fire
   Use fire extinguishers until arrival of Fire Department.
4. Remove patients from adjoining area if necessary.

DO NOT USE ELEVATORS *(in red)*

Code word for fire is "Dr. Firestone."
("Dr. Firestone" is in red)

Figure 2

3. **Method of procedure.** This is an informational card, usually 8x12 inches, framed and posted throughout the hospital in strategic locations, determined by the Fire Department inspector. It tells very briefly, in four or five numbered steps, what to do in case of fire. See Figure 2.

4. **Building or area floor plans.** The building plot plans are floor or area drawings for each floor or area. They show walls, partitions, doors, exits, stairwells, elevators and other shafts, bridges, and tunnels. They also show the type and location of every extinguisher and interior standpipe fire hose. They help each individual employee to understand the entire picture, and help management to know and explain the whole program. See Figure 3, page 24.

5. **Internal fire prevention inspection report.** This is developed by the individual hospital to suit its need. The Fire Department assists by pointing out the special occupancy hazards to watch for in each area, plus the general hazards. All of the hazards present are used in forming the report sheets. See Figure 4, page 25.

6. **Booklet of plan.** The booklet is the entire program approved by the Fire Department for use in that particular hospital. The administrator, each department head, and each supervisor should have his own copy. One should be kept at each nurse's station and at the switchboard. Extra booklets should be kept by each supervisor.

When any new employee comes to work in the hospital, his immediate supervisor should be held directly responsible for the proper training of that employee. If possible, each employee should be given a copy of the booklet. Booklets are to be returned when employment terminates.

FIVE STEPS FOR LIFE SAFETY

When considering a fire-safety program, especially in a hospital in which approximately one-third of the patients are non-ambulatory, life safety must be the primary objective. To best accomplish this, the program used by the Los Angeles Fire Department encompasses five major steps:

I. An internal fire prevention program.
II. Safety to life.
III. Notification of the Fire Department.
IV. Confining and attempting to extinguish the fire.
V. Evacuation if necessary.

It is necessary to discuss each of these steps to thoroughly understand the program. The last four steps, which will be discussed first, are all interrelated, and are not necessarily performed in the listed order.

II. *Safety to Life*

This refers to the protection of the person or persons in immediate fire danger. If the fire occurs in a two-bed room, for instance, it may be necessary to remove both patients. On the other hand, the fire may be in the bed of one of the patients, and it may be necessary to remove only that patient, if the fire is confined to that bed.

The main thing to remember is that the action taken is an emergency measure to safeguard lives that are in immediate danger. It still gives the rescuer enough time to do the other things that must be done.

The employee must be familiar with several carries designed to remove the patient quickly and safely from a bed, and must practice the various carries enough to become proficient in their use and to know which one or ones suit the individual rescuer.

(Continued on next page)

Lt. Robert McGrath, of the Chicago Fire Prevention Bureau, has developed the carries now used by the Los Angeles Fire Department. These carries have been approved by the National Safety Council and are illustrated in the excellent booklet, *Emergency Removal of Patients and First-Aid Fire-Fighting in Hospitals*, which is a joint publication of the National Safety Council and the American Hospital Association. The Los Angeles Fire Department, in its program, uses some of the points brought out in this booklet.

There are six basic carries and several variations of each. The proper carry to use will depend on how many rescuers are available and the size and condition of the person or persons to be removed. If the person is on the floor, a blanket is a very handy tool. The person should be rolled onto the blanket and dragged from the room with the victim head first to prevent injury to the person. If the person is in bed, however, weight and distribution become problems. Therefore, a thorough knowledge of these various carries is essential.

Another big life-safety item is to have a definite system of employee response worked out in advance for each hospital area. A good plan provides, as soon as possible after the alarm has been turned in, at least three people on the fire scene. This can be accomplished in a number of ways. Generally, however, a good rule to follow would be to have the two persons nearest the location of the fire respond immediately to the scene. These two, in addition to the person discovering the fire, then form a fire team. A team of three persons, properly trained, can handle almost any situation for those first few crucial minutes of a fire.

III. *Notification of the Fire Department*

If a switchboard operator is on duty 24 hours a day, the person discovering the fire can report the location to the operator, who then will immediately announce over the public address system, "Dr. Firestone report to" (whatever the location of the fire may be). This sets the hospital fire-safety program in motion. The operator's next action will be to relay the call to the Fire Department.

If a switchboard operator is not on duty 24 hours a day, then the person discovering the fire must sound the alarm

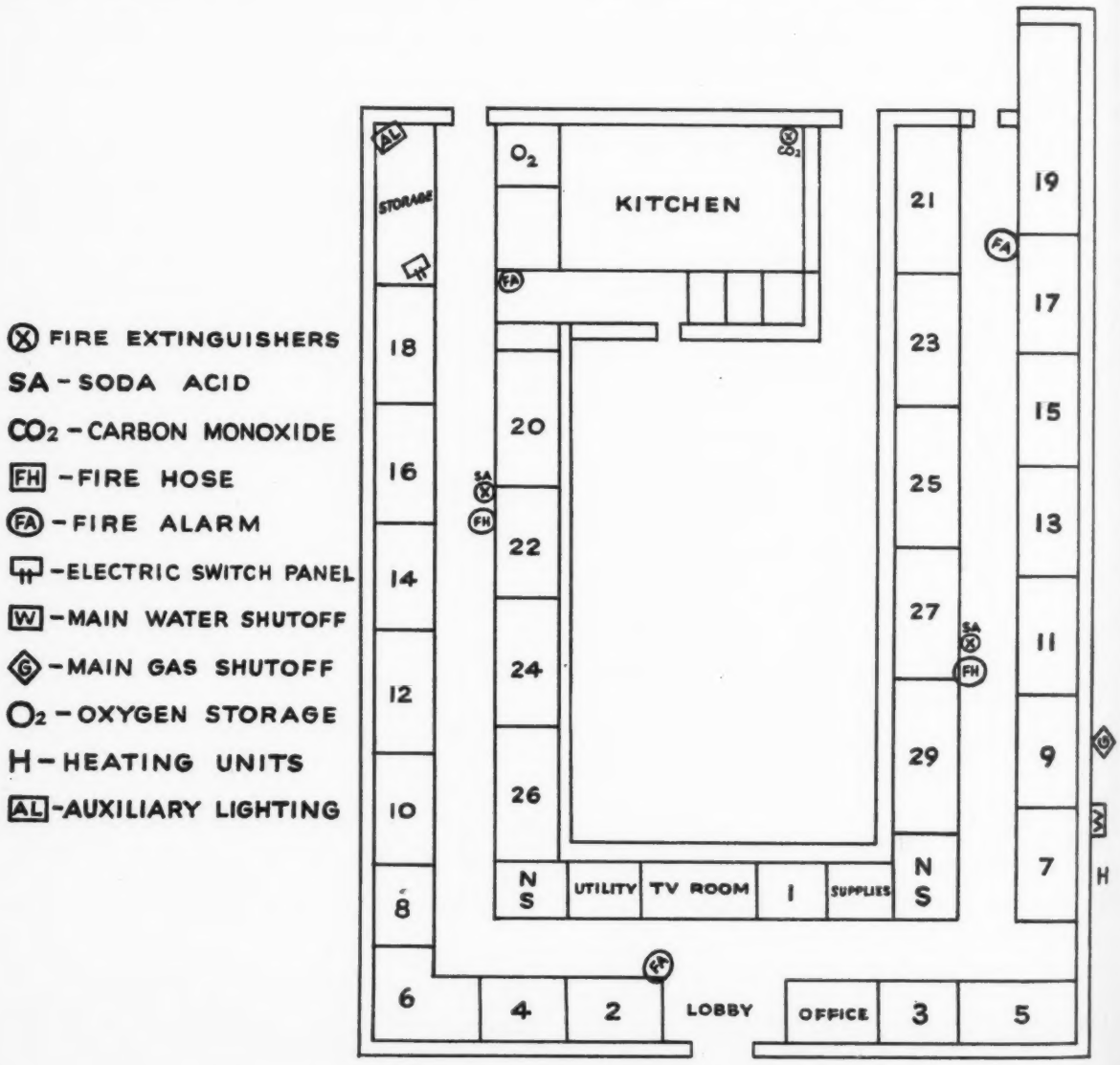


Figure 3

Hospital

Fire Inspection Report

Department..... Date.....
Inspector.....

HOUSEKEEPING:
- .....Good
- .....Poor

WASTE DISPOSAL:
- .....Tight-fitting lids on containers
- .....Waste disposed of regularly and safely

OXYGEN EQUIPMENT:
- .....“NO SMOKING” signs in place and visible
- .....O2 tanks anchored in place
- .....Safe dispensing methods in practice
- .....Adequate ventilation

ELECTRICAL EQUIPMENT:
- .....All equipment correctly fused
- .....Wiring and connections in good condition
- .....No electric cords hung over nails

FLAMMABLE LIQUIDS: LABORATORY DEPT.
- .....“NO SMOKING” signs in place and visible
- .....Open-flame devices at least 25' away
- .....Safe dispensing methods in practice
- .....Adequate ventilation

ADDITIONAL:
- .....Dust explosion hazards kept cleaned up
- .....All aisles maintained clear

FIRE EQUIPMENT:
- .....Fire extinguishers
- .....Fire hose lines
- .....Sprinkler control valves open
- .....Sprinkler heads unobstructed

HEATING APPLIANCES:
- .....Properly installed and located
- .....Adequately ventilated
- .....Properly maintained
- .....Combustibles removed from immediate area

INSPECTOR'S REMARKS AND RECOMMENDATIONS:.....

DISPOSITION:.....

SAFETY COMMITTEE NOTE:

1. Reports are to be made out weekly by individual departments
2. Send report to safety committee chairman
3. Recommend that personnel in departments take turns at completing reports, giving all a chance at knowing fire regulations

Figure 4

and call the Fire Department. *There must be no mistake about this.* Anyone who discovers a fire and does not report it to the Fire Department IMMEDIATELY should be dismissed.

There is no greater cause for large losses in fires than delayed alarms. Once people are aware of this, there is no longer any excuse for delay. When helpless persons are dependent upon the proper action of hospital employees for their very lives, careless or premeditated delay approaches a criminal action.

The switchboard operator should also be responsible for sending a dependable person to the curb at the front entrance. This person then can save valuable time by directing the Fire Department to the exact location of the fire. After announcing “Dr. Firestone report to—,” calling the Fire Department, and sending a dependable person to direct the firemen, the switchboard operator can make the other necessary calls. She must, however, keep as many lines open as possible for fire use.

In the November issue, the authors will discuss steps IV and V—confining and attempting to extinguish the fire, and evacuation if necessary.

(Continued on next page)

Every Hospital Needs a Fire Safety Program

A group of employees being "prepped" before extinguishing class A, B and C fires.

By Robert H. Wright*

● A modern hospital? A new building constructed from fireproof materials? No danger of fire?

Unfortunately, there is grave danger in ANY hospital, no matter how up-to-date its building materials may be. Empty, it may be fireproof. But bring into the hospital operating rooms, anesthesia equipment, a complete kitchen, laboratories, a laundry, shops and stockrooms—and add hundreds of human beings—and you are filling the hospital with potential fire hazards.

Few people today realize the possibility of fire in a modern hospital. Too often they let structural materials lull them into a false sense of security.

For this reason, officials at Morristown (N.J.) Memorial Hospital, have instituted a regular fire-safety program in a building which is less than five years old. Responsibility for the program falls on a fire marshal, who maintains and trains an active fire brigade, makes regular building inspections, and conducts a continuous campaign to keep all hospital employees alert and aware of possible fire hazards, using posters, films, and employee education.

Larger hospitals may have a paid fire department with regular man hours and rolling equipment, but hospitals like Morristown Memorial, with 272 beds, can efficiently maintain their own fire-safety program—if it is properly and conscientiously carried out. Every hospital should.

The training of a fire brigade in smaller hospitals takes on the aspects of training a municipal volunteer fire department. Our brigade consists of all men employees, who without prior notice, and at any hour of the day or night, are called to monthly practice.

Alerted only by the code number on the hospital alarm system, giving the location of the supposed fire, the men reach for the nearest fire extinguisher and rush to the scene. Variety is the key to the brigade's successful practice.

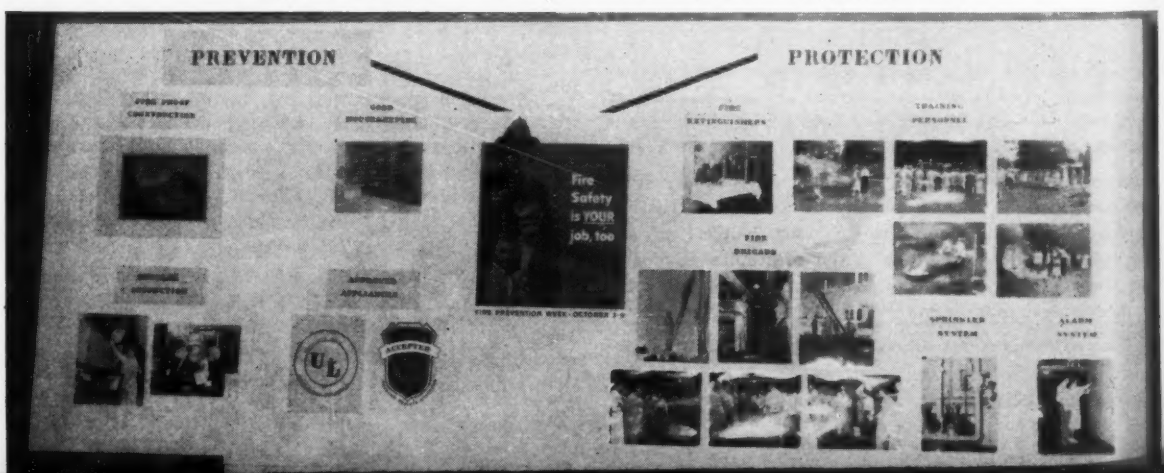
Brigade members do not know whether they will man the hose lines, work with the extension ladder, or be asked to put out an oxygen tent fire. They are taught how to carry patients from their rooms, using the proper carry; they learn which type of extinguisher to use on which type of fire, the importance of ventilation, and other fire-fighting technics.

Besides being the first line of fire-fighting defense, they are also familiar with other pieces of fire-fighting equip-

(Continued on page 30)

*Fire marshal, Morristown (N.J.) Memorial Hospital.

Poster display for Fire Prevention Week—part of extensive program of employee education.



*Trademark

check these added advantages:

ready to use—just dip, squeeze and apply... requires half as many bandages as ordinary plaster casts

correct drying action—no waiting... allows trimming time, then hardens to full strength promptly

makes more comfortable, better-looking casts—lighter, thinner, smoother... yet much stronger than heavier, clumsier casts of old-style plaster

makes more durable casts—retains strength despite humidity, never crumbles or grows soggy... resists water, urine, perspiration, mold ... remains odor-free

costs less per cast than plain plaster!

Next time you need plaster bandages, specify modern, easier-to-use MELACAST in the new, plastic-lined, moisture-proof package . . . another outstanding development from Surgical Products Division.

SURGICAL PRODUCTS DIVISION, AMERICAN CYANAMID COMPANY, DANBURY, CONNECTICUT

CYANAMID PRODUCERS OF DAVIS & GECK SUTURES

50 CYANAMID 1907 1957

DISPOSABLES: Hospitals Find 'Things Cheaper Than People'

A man long active in research and development of new products for hospitals takes a look at disposables today and makes a few predictions for the future.

By Harry K. DeWitt*

● It's taken a postwar surge in census plus fantastically increased labor costs to change our attitudes, but today more and more hospital people are saying, "Use it, and throw it away." Result: The big breakthrough is upon us in disposable items.

A great deal of mental readjustment is needed to switch from "make it do" to "use it and throw it away." When costs exceed income, the normal, human tendency is to say, "Clean it up, patch it up, make it do." However, as some smart administrators found, "cleaning it up and patching it up" costs more than throwing it away and buying a new one. The higher wages have soared, the truer this has become. It can be proved that sometimes things really are cheaper than people.

Just as an illustration, it costs about 20 percent as much to use a paper wrap for sterilizing hypodermic needles as it did to scrub, rinse, and stopper the vial formerly used. And research has proved that a new glassine will permit steam and heat to penetrate to the needle, yet will provide a sterile seal for months. Sterilizing wraps of this and other substantially improved papers have proved ideal in packaging and sterilizing syringes, needles, catheters, gloves, etc. Instead of cloth wraps to wash, mend, and take up excess storage space, there is thin glassine that can be quickly, easily handled, sterilized—and *thrown away.*

Diapers and underpads have been strongly established in the disposable field, too, making paper products ever more common in hospitals.

Plastics and metals loom bigger every day, also. The labor savings from disposable needle and syringe wraps led quickly to envelopes and wraps for instruments, gloves and, later, soft goods. Take sterile plastic IV sets, for instance. Used once and thrown away, they actually cost less, with today's hospital wage scales, than cleaning and re-using the old-fashioned, so-called "permanent" dispensing sets.

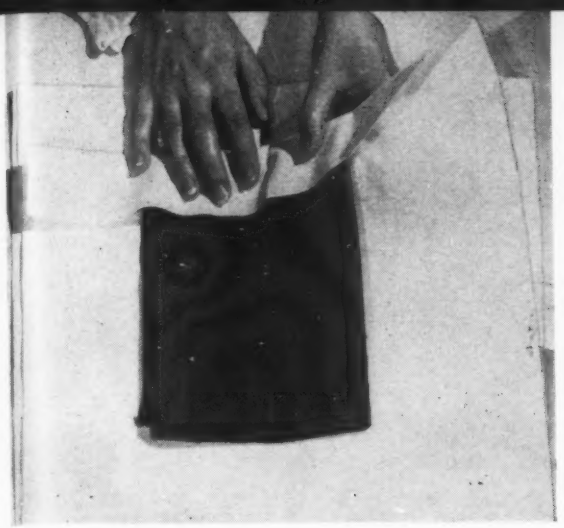
More often than not, disposables actually improve technics. For example, the first disposable blood lancet struck effectively at a prime source of hepatitis. The relief appears to be well founded that disposable oxygen-tent canopies and oxygen masks sharply reduce the hazard of cross-infection; that disposable salt, pepper, and sugar packets, paper creamers, and paper or plastic straws contribute toward the same end.

A new plastic, disposable emesis basin; disposable plastic stomach tubes and rectal and oxygen tubes; disposable drainage containers, colostomy bags, blood-sample containers, specimen bottles, and disposable enema units are a few of the things that have released trained, expensive personnel to do more complex jobs and, at the same time, have made possible better and more individualized care in our hospitals.

An example of direct economy in use is the new disposable emesis basin. Research showed that the cost of handling and sterilizing conventional emesis basins exceeded nine cents per patient. The new disposable basin costs less than a nickel in quantities most hospitals need, and provides one more individualized, personalized service for the patient. The disposables also have dissolved handling bottlenecks, cut traffic, and reduced storage space demands.

(Continued on page 30)

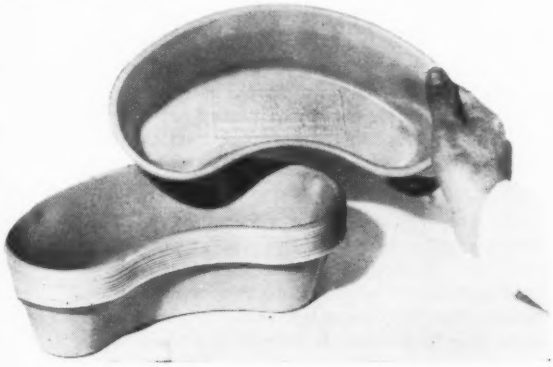
*Mr. DeWitt is vice-president in charge of sales, American Hospital Supply Corp., Evanston, Ill.



Above: These disposable sterilizing wrappers are used in the preparation of a variety of hospital items for autoclaving. Wrappers are made of a special white flexible paper which is resistant to liquid water, yet has a high moisture-vapor permeability, needed for effective sterilization.

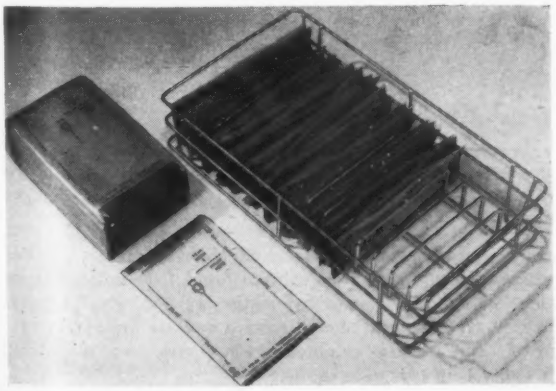
Right: Divided syringe packets, used in syringe sterilization, have individual pockets for syringe barrels and plungers. This prevents chipping caused by accidental meshing during packaging and handling. Matched parts can be kept together.

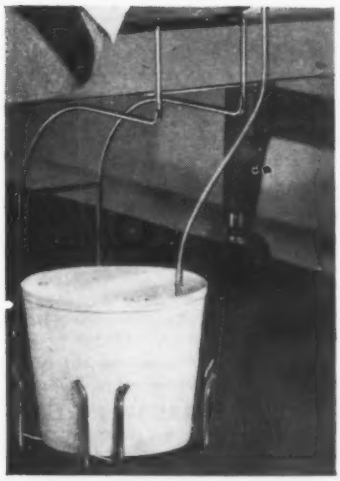
Below: Flexible emesis basin cuts cost—provides fresh basin for each patient's personal use. Eliminates autoclaving necessary when metal basins are used.



Right: Disposable combination administration set and pressure pump is a complete, ready-to-use blood set, except for injection needle. Blood may be given at the normal rate or rapidly under pressure by squeezing and releasing built-in flexible drip device.

Below: Transparent glassine wrap has self-sealing adhesive ends—can be used for needle sterilization. Color borders on each wrap provide easy identification for the needle gauges.





Left: These disposable containers are used for the collection of body fluids and wastes. They eliminate high labor costs and unpleasantness of handling, cleaning and sterilizing glass jars.

DISPOSABLES

(Continued from page 28)

Modern, unit packaging of expendables is streamlining technics, too. The new disposable enema units are a case in point. Nurses need not bother with elaborate containers, tubing, and irrigating stands which take so much time to assemble, use, and resterilize.

IDEAS COME FROM HOSPITALS

Ideas for the majority of new disposables come from within the hospital, just as have most important technical and service advances. The physician, nurse, hospital department head, and administrator lead the way in suggesting new expendable items. Often, however, a manufacturer will develop a faster method of producing his product, putting the unit cost within the range of disposability.

Most needed now is closer cooperation between hospital and manufacturer to speed development of these time-saving innovations.

THE FUTURE IN DISPOSABLES

The growth of disposables depends on two things: ideas and raw materials. Ideas will come as people recognize ways to do their job faster and better. New plastics, metals and paper products will open the way to the fulfillment of these ideas.

Practical, disposable syringes and needles seem to be near as the right materials and designs are combined for mass-production economy. Paper drapes and surgical kits are already here in quantity.

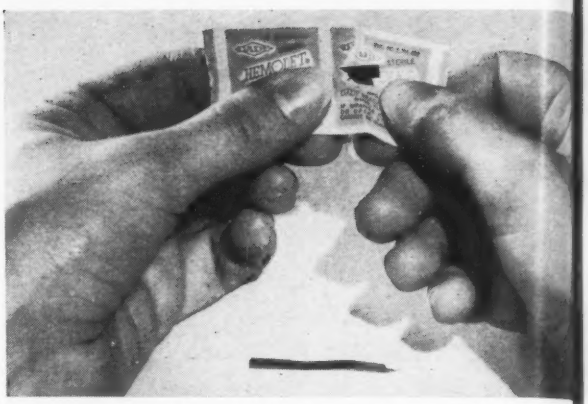
It's not too optimistic to think that one day gowns for patient clothing and for surgical teams will be made of suitably disposable paper. One step further—perhaps sheets and pillowcases will not always be a heavy laundry and maintenance expense.

In the future there may well be a surgeon's glove that is expendable, a safe nursing bottle and nipple for one-time use, and food-serving dishware and tumblers that are attractive, heat-resistant, sturdy, and disposable.

Almost any turn of the imagination will lead to a hospital product that may join this growing array.

One thing is certain already: As hospital responsibilities and services continue to expand, there will come a greater need for products that save time and improve technic. This the disposable product has done and will continue to do.

At present wage scales, dozens and dozens of throw-away items are within the realm of possibility. When they come, they will be "cheaper than people," and will produce still greater economies in hospital operations.



Pictured: A disposable sterile blood lancet. Each razor-sharp stainless steel lancet is packaged in its own sterile envelope.

For additional material on disposables, see pages 31 and 32 and also the central supply department, page 131.

FIRE SAFETY PROGRAM

(Continued from page 26)

ment, should the local fire department be called. Films, group practice, and pantomime scenes keep the drills from being anything but cut and dried.

Members of the brigade serve as volunteers, as a side job, without pay. A fire marshal can also have additional duties in the hospital, as I have, but should be chosen for his qualifications and interest in the work.

My own enthusiasm for setting up and maintaining my hospital's fire prevention program stems from my association with a municipal fire company, of which I am ex-chief, and present activities in firematic associations on both county and state level.

In addition to the brigade's regular training, a twice-yearly fire drill is held for all employees. The drill is a comprehensive lesson in the use of fire-fighting equipment, and all employees take turns actually putting out flammable liquid and combustible solid fires. Old mattresses, dressers, draperies, and wastebaskets are set on fire during these outdoor practice sessions.

Photographs of these fire-fighting lessons are put on bulletin-board displays, along with posters lurid enough to attract all employees' attention, as part of our year-round educational program.

Fire protection and fire prevention in today's hospitals, whether they are new or old buildings, should not be overlooked or minimized. In older structures, with narrow corridors and cramped facilities, everyone should be ever on the alert and prepared for any potentiality of fire and its disastrous outcome.

In new buildings, which are pointed out with pride by the community, management must not relax with the thought that it cannot happen here. It can—it can happen any day.

It is the hospital's responsibility, not only to minister to the sick and save lives, but to protect its patients from the perils of fire caused by negligence and wishful thinking. Every hospital should have a definite fire-safety program, and trained employees who know how to combat fire and help evacuate patients.

TO SAVE OPERATING ROOM TIME and TO HELP THE SURGEON

Use *Steri-Spools in a Halliday Wire Dispenser

You get the size and length of sterile wire you want as you want it.

NO SNARLS — NO KINKS NO WASTE

If your dealer cannot supply, write to the manufacturer—

THOMAS W. HALLIDAY
911 N. WESTMOUNT DRIVE
LOS ANGELES 46, CALIF.

*Trade Mark Registered

Paper Container Gains Wide Acceptance In Food Service

By Browne Sampsell*

• In more than 70 percent of American hospitals, the paper container now appears on the patient's tray, in the cafeteria, at the nursing station—for administering medications, and in the laboratory and x-ray departments.

A number of sound reasons account for its popularity. One of them is the saving of time. With paper food service, dishwashing is out. As an example of the time consumed in doing that chore, an actual time study at the Kingsbridge Road VA Hospital, New York City, showed that during a 24-hour period in all the wards, a total of 48 hours and 39 minutes of nursing time was spent in washing and sterilizing glasses. In a year's time that would amount to 17,757 nursing hours and would equal the full-duty time of 10 nurses.

A New York hospital test revealed that the use of paper containers in isolation cases saved two hours of nursing time that formerly had been required to sterilize dishes and glassware.

Paper service saves time also because it eliminates return trips to the kitchen with dishes and glasses. Nourishment dishes need not be collected from patients between meals. The patient or the attendant simply crumples the paper container and tosses it into the wastebasket. Paper food service relieves the nurse or dietitian of the duty of weighing foods for special-diet patients. It is much quicker to measure the foods into portion paper cups.

The paper container saves labor. No bussing, scraping, washing, racking, or replacing utensils is required. The labor of getting soiled dishes from the patient to the dishwashing station and back again to where they can be readied for another trip is eliminated.

During the World War II manpower shortage, Sunny Acres, a 650-bed county TB hospital near Cleveland, was able by the use of paper service to get along with 11 less employees. After the Los Angeles County General Hospital (3,000 beds) installed paper food service, it was able to make a net reduction of 74 employees, mostly kitchen helpers in the dishwashing and food service section. When they used crockery dishes, a strong man was required to push one food cart. Now one female employee can handle two carts, and one attendant carries two of the light food trays, one in each hand.

Furthermore, paper food service is more economical. The administrator of Point Pleasant (N.J.) Hospital, reported after a test of complete paper service that "because of the substantial savings in dishwashing labor (two full-time jobs and one half-time job eliminated), breakage, soap, laundry, electricity, the paper service more than pays for itself." According to the test, the average cost of paper service for a patient's complete meal was 4.23 cents.

The average tray set-up per meal in Lincoln (Nebr.) General Hospital contains about six paper dishes and cups which cost from four to five cents. This adds up to 12 or 15 cents for the three meals a day service and results in a net saving of 45 cents per patient per day. During the polio epidemic of 1952, all-paper service saved the day for this hospital.

The Los Angeles County General Hospital reports that it has saved in excess of $600,000 since it began to use paper containers 12 years ago. Sunny Acres Hospital estimates savings in one year (1952) of $7,700.

Food portion cups are another means of reducing expenses. They enable the administrator to keep track of portions used and thus are able to keep waste of food at a minimum.

Some administrators feel that since their hospitals already own dishwashing equipment, the use of paper would not save them much. But machinery wears out—accountants give it a 10 year life—and replacement means considerable cost. In the meantime, repairs and maintenance pile up expense.

Another consideration is that china must be replaced not only because of breakage but because high temperatures of washing and sterilization remove its glaze. Also, of course, it is as easy to break glassware by using too hot water as it is to drop it accidentally.

Paper containers save space. They can be stacked sky-high in small cabinets one over the other with no danger of breakage or chipping.

Other advantages of paper containers are:

1. They are durable. Modern plastic-coated paper plates withstand meat cutting and do not soak up gravies or sauces.

2. Lidded paper containers protect individual portions for special-diet patients from dust and other contamination during transit.

3. They furnish an easy means of identification, with space on the lid to write the name of the patient or his room number.

4. The lighter-weight tray speeds up room service. A china and glass food service without tray weighs 6 lbs., 4 oz. A matched paper food service without tray but with similar food items weighs 4 oz. Two paper food-service trays can be carried at a time, one in each hand, thus doubling the number of patients who can be served in a given time.

In isolation cases the paper container eliminates collecting, washing, and sterilizing used dishes and cups. The nurse puts the contaminated paper containers in a trash receptacle, and later they are burned. And no one need worry about cross-infection from eating or drinking out of contaminated vessels.

Today's hospital uses paper medicine cups for both liquid and dry medication. Because they are graduated in cubic centimeters, ounces, and teaspoons, the nurse can quickly and accurately measure medication. Their wide base prevents upsets. Space is provided to record time or directions for administering. Paper medicine cups are

(Continued on next page)

*Miss Sampsell, a free-lance writer, acknowledges the aid of the Dixie Cup Co. in preparing this article.

used also to measure bath oil for babies, and mouth washes and gargles, and to hold laboratory specimens, thermometers, gauze, cotton, and pellets.

"We have found them particularly useful in giving mineral or castor oil," says the director of nursing at the Morrell Memorial Hospital, Lakeland, Fla. "Besides being non-breakable, they don't have to be washed. It is almost impossible to get oil out of a medicine glass. We have still another use for medicine cups. We put coffee cream in them."

Big paper mugs are used to administer barium in the x-ray room, because, according to St. Helen's Hospital, Chehalis, Wash., "paper mugs cut the labor of cleaning up considerably. Much time is saved by the technician, as barium clings to utensils and glassware and is hard to remove."

Patient reaction? In a survey of 650 patients representing high and low incomes, only four requested china. In a two-month test period of paper service at Point Pleasant (N.J.) Hospital, 98 percent of the patients found nothing wrong with the taste of the food, coffee, or other hot drinks. Eighty-five percent reported that they had no difficulty in eating from any of the dishes, and that since paper containers do not slide as much as china, less food is accidentally spilled. Again if the weak little hand of a child, or the shaky, arthritic hand of an adult accidentally drops a paper container, neither patient nor hospital has anything to get upset about.

Patients generally appreciate "hospital clean" dishes at every meal, and can have no fears that dishes may have been carelessly washed or improperly sterilized. They are grateful for the lighter food tray. They also like the absence of the clatter of food carts, stacked with clinking china and glassware, and the din of setting up trays and loading the dishes on racks and putting them into the dishwasher.

With the varied paper food service available today, the tastes of the most fastidious and demanding can be satisfied. One firm alone puts out 500 different sizes and types of containers. Matched paper food service may be had in colors or pure white with pleasing designs. One paper-cup manufacturer delights children and grown-ups as well with a juice cup in orange and green design of 28 oranges arranged around the top, some cut in half with drops of juice dripping from them.

In addition to plates, cups and dishes, place mats, doilies, coaster trays, wet-strength cocktail or dinner napkins are available to contribute to the comfort, the convenience, and attractive appearance of the patient's paper food-service tray.

Cost Comparison Between Flexible Paper Straws* and Breakable-Type Tubes

A survey on the comparative costs of glass straws and disposable straws was made recently in the two units of the Youngstown (O.) Hospital. Results are shown in the table below. According to Jack Maikrantz of the hospital staff, some of the reasons which led to the use of disposable straws were: desire to insure sanitary straws for the patient, who appreciates individual service; safety—with glass there is always the danger of breakage, which causes accidents; convenience—flexible straws can be bent in any position, whereas glass straws are in a fixed position. Hospital officials were surprised to find that the flexible straws also were cheaper.

Survey Conducted at Youngstown (O.) Hospital, North and South Units, Total Both Units, 800 Beds

	Flexible Paper Straws South Unit-400 beds		Breakable-Type Tubes North Unit-400 beds	
Survey Months 1956	Patient Days	Boxes of 500 Used	Patient Days	Replacements
Six Months April through September	Approx. 60,000	178 Boxes, (89,000) straws	Approximately 60,000	5,200 tubes
		Costs		**Costs**
COST OF TUBES:	89,000 Flexible paper straws @ $3.95 per M-Each straw $.0039	$351.55	5,200 Replaced tubes. Breakable tubes per gross, $2.00. Each breakable tube $.014	$72.80
CLEANING (LABOR)	Disposable	0.00	520 hours labor	390.00**
CLEANING (MATERIAL)	No upkeep costs or cleaning	0.00	Brushes and detergents	20.00
TOTAL COSTS	ORIGINAL COST THE ONLY COST	$351.55	TUBES, LABOR, AND MATERIAL	$482.80

CONCLUSIONS: Net savings of $131.25 over the six-month period by using Flexible paper straws.

*FLEX-STRAWS supplied by Flex-Straw Co.

**Breakable tubes cleaning requires two hours nurses' aide time per week per floor (10 floors for the 26-week survey period). Labor cost figured at 75c an hour, a very conservative estimate.

TOPICS' SPECIAL REPORT ON:

AHA

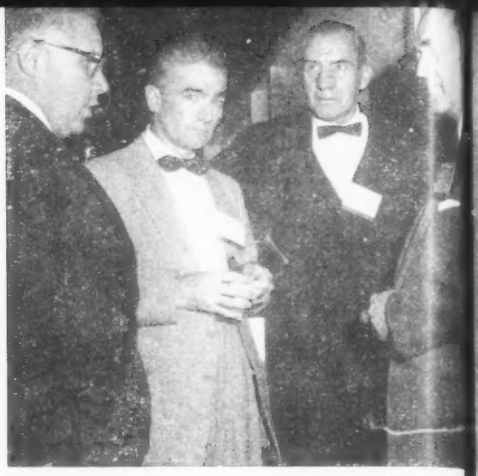
Convention – Atlantic City

COLD weather and rain didn't seem to dampen the spirits of the 11,377 persons who turned out for the 59th annual convention of the American Hospital Association in Atlantic City, Sept. 30-Oct. 3.

Theme of the meeting was "Keep Pace with Progress." Convention-goers did just that by attending sessions and by flocking into the exhibit hall (as shown here).

Not Much of This.....

But Lots of This



John Steinle (l.), consulting editor, HOSPITAL TOPICS, talks over mutual problems with D. J. Daley, M.D., United States Public Health Service Hospital, Baltimore, Md.; John L. Wilson, M.D., medical officer in charge, United States Public Health Service Hospital, New Orleans, La.; and John W. Cronin, M.D., assistant surgeon general and chief, Bureau of Medical Services, United States Public Health Service, Washington, D.C.

House Asks Federal Funds For Nursing Education

Amberg New President-Elect

The House of Delegates ended its three-day session with a quiet morning meeting at which Ray Amberg, director, University of Minnesota Hospitals, Minneapolis, was named president-elect.

Elected to three-year terms on the board of trustees were Rear Adm. Bartholomew W. Hogan, M.C., USN, chief, Bureau of Medicine and Surgery, Department of the Navy, Washington, D.C.; the Rt. Rev. Msgr. Edmund J. Goebel, director of hospitals, Archdiocese of Milwaukee, Milwaukee, Wis., and Carl C. Lamley, executive director, Stormont Vail Hospital, Topeka, Kans.

The House, at its final session:

•Approved seeking federal funds for professional nurse education.

•Voted to seek a five-year extension of Hill-Burton (which will expire in 1959), the addition of a program of grants for renovation and improvement of existing hospitals, and a long-term, low-interest loan program for both construction and renovation and modernization.

•Accepted a recommendation that the AHA not seek a change in the basic Hill-Burton formula.

•Reaffirmed its 1956 action on Medicare, urging support of Blue Cross as the agent, and use of the Blue Cross formula by hospitals in this program.

•Approved a statement describing plans for increased AHA activities in nursing—which would probably include a department of nursing within the staff structure of the association.

•Unanimously adopted a set of guiding principles for use by the Standing Committee on Nominations of the House. Ritz E. Heerman, committee chairman, before presenting the slate to the House, said in a special report that the committee believed "the time has now come for an expression of general guides which succeeding committees can use as they deliberate in coming years." He said the committee "was alarmed about the increasing tendency to inaugurate organized campaigns for the office of the president-elect . . . The committee feels that the endorsements are quite proper and necessary but that they should be considered as much a matter of trust by the writer as would any other letter of recommendation he would write."

After the committee's nominations had been voted, Delegate Guy M. Hanner of Arizona asked and received unanimous consent of the House to consider establishing the principles as policy.

See special exhibits report immediately following this 16-page section.

See also the November issue for additional news and pictures from the meeting.

Human Attitudes As Vital As Scientific Aptitudes

Hospitals Must Combine Service with Skill

Hospitals must develop as institutions of human relations to keep pace with advances in science and technology. Like universities, hospitals are in danger of cultivating an ivory-tower attitude toward contemporary problems. If hospitals are to do their part in helping the world keep its patterns for more abundant living ahead of its technics for more efficient killing, they must recognize the importance of human values and attitudes as well as scientific aptitudes.

Higher education is widening the scope of its program and must continue to add needed programs of training, as it has done in the last 20 years, for example, in education for hospital administration. The tendency toward greater division of labor and specialization will grow, and the future will be characterized by variety even more than the present.

By 1970, the number of American youth between the ages of 17 and 22 will have doubled, and the number of

(Continued on Page 4)

When the sun finally came out after two cold, cloudy days, among the conventiongoers who enjoyed the sea air and sunshine were these two Sisters of Charity from Providence Hospital, Washington, D. C., student nurses at Catholic University.

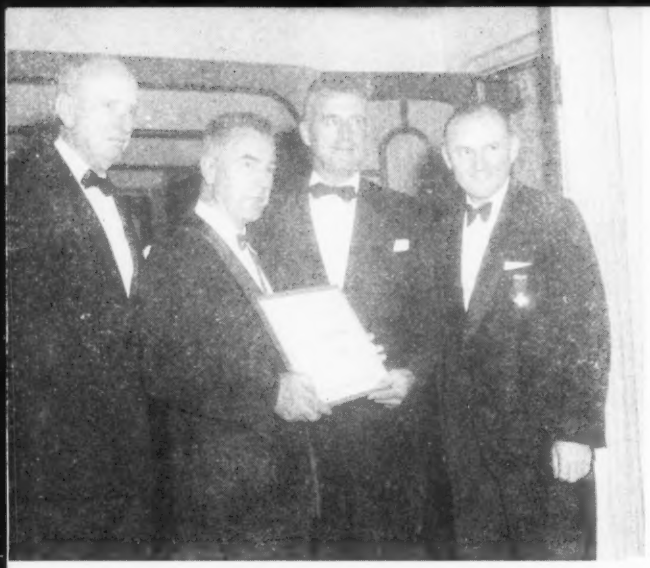
Ford Foundation Grants $825,000 For AHA Counseling Program

An $825,000 grant by the Ford Foundation, to help the AHA conduct a five-year counseling program for hospitals, was announced at the meeting by AHA president Albert W. Snoke, M.D.

The grant, which will enable the association to offer on-the-scene administrative counseling to hospitals requesting it, will be made to the Hospital Research and Educational Trust, a nonprofit organization separate from the AHA.

It is anticipated that the program will be carried out through hospital visits by teams of counselors, according to AHA executive director Edwin L. Crosby, M.D. Prior to the visit of the counseling team, the hospital would be sent information, including data sheets to be completed in advance, and an outline of the procedure to be followed during the survey.

Interviewers will talk with the hospital administrator, members of the governing board and medical staff, and department heads. Survey findings will be classified to identify areas in which "the efficiency and adequacy of the hospital's operation may be strengthened."



John H. Hayes (l.), Douglaston, N. Y., recipient of Distinguished Service Award, and Edwin L. Crosby, M.D. (r.), Chicago, executive director, AHA, watch Albert W. Snoke, M.D. (second from l.), New Haven, Conn., AHA president, present honorary membership certificate to Rep. John E. Fogarty, Providence, congressman, second district, Rhode Island.

Above: Albert Hahn, Evansville, Ind., executive director, Indiana Hospital Association, and Mrs. Hahn (r.), assistant executive director, enjoy chat outside banquet hall.

Below: New AHA president-elect Ray Amberg (l.), Minneapolis, director, University of Minnesota Hospitals, pauses before annual banquet with Msgr. M. J. Thornton, Sea Girt, N. J., president, Catholic Hospital Association.

student nurses will also have doubled. However, the number of medical schools and medical students will not have increased substantially because facilities cannot expand at that rate. Moreover, there is a feeling that many of the services now performed by M.D.'s can be performed by technicians under medical direction.

A variety of programs are developing to meet the needs of the future in nurse training. One such program calls for training at three levels. The first level is a one-year post-high school course in practical nursing, leading to a certificate and preparing for general duty, floor, or home nursing. The second level will be the three-year training program leading to an R.N. and preparing for special skills and supervisory positions, and the final level will be the collegiate school of nursing, leading to a university degree and providing teachers and administrators for the profession. The first two programs would be conducted in the hospitals and the third in hospitals in cooperation with the major universities.—**Carter Davidson**, President, Union College and Chancellor, Union University, Schenectady and Albany, N. Y.

Health Care Faces Liability Areas

Better Protection, Personal Touch Needed

Although tremendous progress has been made in medicine and health in the past 30 years, the following liability areas remain:

1. Better public education is needed in the rules of healthy living, the importance of seeking medical help when needed, and the avoidance of charlatans and quacks.

2. More people must protect themselves with prepaid health insurance. Insurance companies must be encouraged to expand into broader fields and to offer coverage for catastrophic and long-term illness at a price the average citizen can pay.

3. The cost of hospitalization must be reduced as much as possible. One step would be for all hospitals to adapt the methods of modern business and industrial management to their requirements.

4. Hospitals need to regain the personal touch.

5. Our system of medical education should be reappraised with special consideration given to decreasing the length and cost of the physician's training.

6. Physicians tend to think of the patient as a problem to be solved rather than as a person to be helped, and to rely too much on tools and tests. The physician must think of himself as a man of service as well as a man of science.

During the next 30 years most of the communicable diseases will probably be eradicated, and certain mental diseases will be controlled through drugs. Thanks to the increasing number of older people, degenerative diseases will become of greater concern. The field of surgery will be narrowed as more conditions become amenable to medical therapy.

The trend toward specialization in medical practice will increase. There will be more group practice in clinics which will be staffed and equipped to furnish complete care for the ambulatory patient.

More hospitals will be located in suburban areas and smaller communities. Large institutions in metropolitan

areas will increase their patient capacity through addition of wings and annexes for care of the convalescent, the chronically ill, and the patient who needs rehabilitation.

Strenuous effort will be made to have government participate more and more in the field of medicine. Those who advocate a system of medical care financed and controlled by the government will win minor skirmishes, but I do not believe they will win the major battle. However, the work of the Public Health Service will be greatly expanded. An increasing amount of federal money will be appropriated for support of research and hospital building programs, and many will advocate similar support for medical education.—**Julian P. Price, M.D.**, Chairman, Board of Commissioners, Joint Commission on Accreditation of Hospitals, Florence, S. C.

Hospitals Called Accountable To Public for Information

For Good Public Relations
Tell of Job Well-Done

Hospitals should not only do a good job of providing medical care. They must also do a good job of telling the public what they have done. Hospitals and government have an interdependent relationship since both have a responsibility to see that the health needs of the people are met. Both government and hospitals derive support and funds from the public, and thus both share the mutual responsibility of accountability.

The objective of government aid to hospitals through grants-in-aid, installation of special equipment, and assistance to hospital management has always been more effective service to the patient. Since governments, like hospitals, are accountable for the use they make of public resources, they must inform those from whom they seek support.

We must keep saying the things that ought to be said and maintain an open-door policy for representatives of news gathering agencies. Publicity is not an end in itself. The only measure of its effectiveness is the contribution it makes to informing the citizens of the facts.

This is not always easy to accomplish because there is tremendous competition these days for the attention of the public. Sometimes it is not possible for a hospital or a government official to give out all the information he knows. However, effective coverage can be assured by establishing a cooperative working relationship with the press, and by treating all situations with honesty and as much candor as possible.

The sure way of alienating the press and the public is by treating hospital news in an arbitrary manner. There is no substitute in public relations for old-fashioned Main Street simplicity, honesty, and candor.—**Robert B. Meyner**, Trenton, N. J., Governor of New Jersey.

Hospital Appearance Should Reflect Its Changed Functions, Attitudes

75% Increase in Number of Persons
Cared for per Year per Bed

The appearance and design of the hospital today are important factors in determining the attitude of the community toward the institution. The hospital has changed in its functions and attitudes toward the community, and this change should be reflected in the appearance of the hospital building as well as in the service it provides.

Good lighting and pleasant, spacious rooms, foyers, and halls are as important in a hospital as technological skill. The current emphasis on modern architectural design in both federal and nonfederal hospitals expresses the astounding improvement in professional services and the broadened concepts of hospital utilization. An indication of the closer relationship between the hospital and the community is the expansion of hospital care to include such special units as tuberculosis hospitals, chronic care and rehabilitation units, and mental institutions.

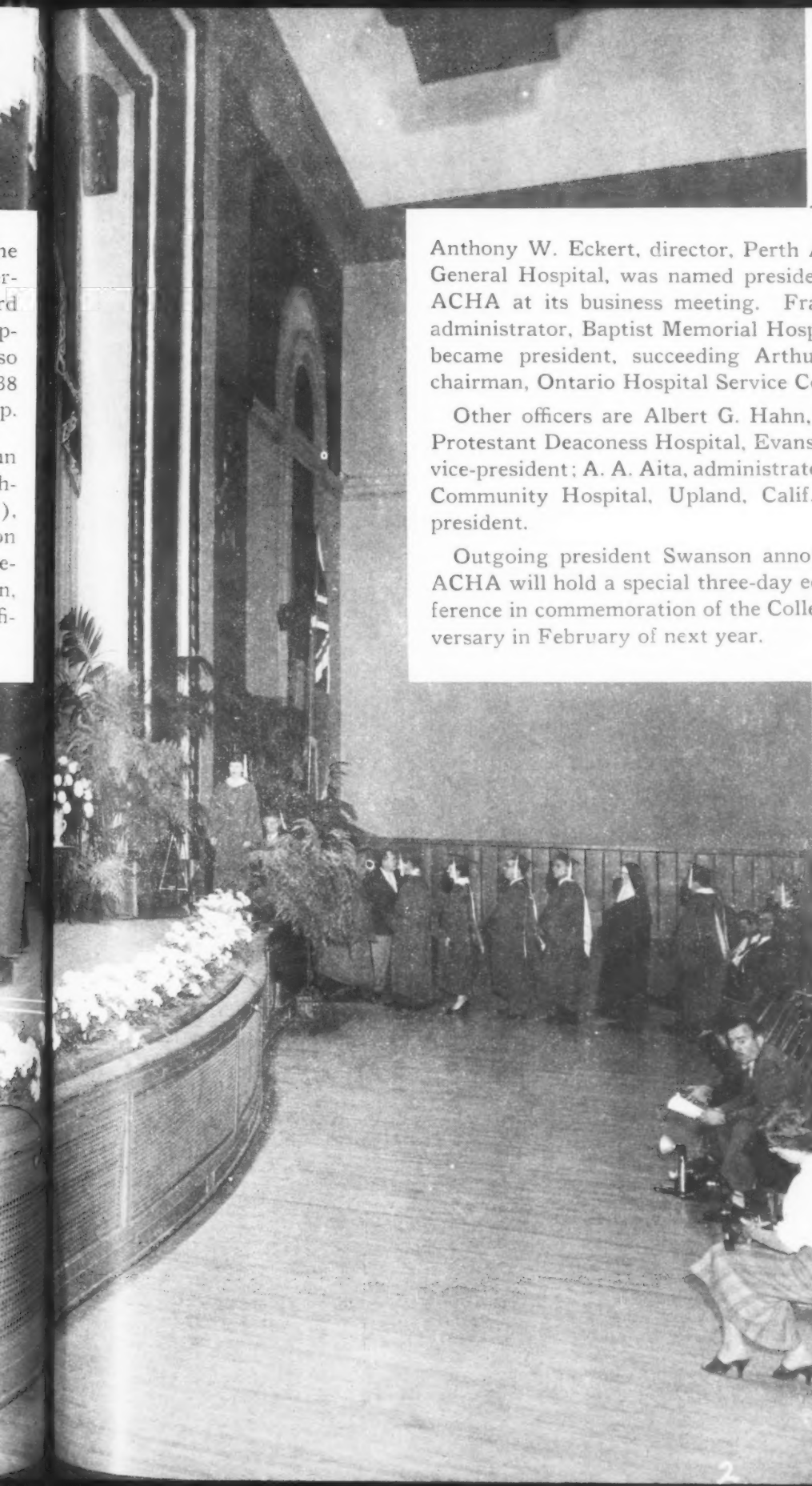
Modern concepts of care have made a tremendous increase in patient capacity possible. In the last two decades there has been an increase of approximately 75 percent in the average number of persons cared for per year per bed.

With the growth in complexity of the hospital, management has become increasingly important. Even with better construction and equipment, excellence of management is necessary if the hospital is to reflect a high level of medical care. The hospital must tie itself into the community it serves, and good management will promote good community relations.—**Maj. Gen. Howard McC. Snyder, USA**, Physician to the President of the United States, Washington, D. C.

Below, left: Charles F. Wilinsky, M.D., Boston, past president, AHA, and distinguished service award winner, poses with Mrs. Wilinsky at annual banquet. Below, center: Joseph G. Norby, Milwaukee, also a past president of AHA and a distinguished service award recipient. Below, right: D. T. Burton, M. D., medical director, Burton-Mercy Hospital, Detroit, and Mrs. Burton, at banquet.

Honorary fellowships for "outstanding contributions to the field of health" were conferred on four persons by the American College of Hospital Administrators at its twenty-third convocation, held in Atlantic City's Convention Hall, September 29, 1957. During the ceremonies, the College also honored 97 of its members with fellowships, named 238 nominees to membership, and admitted 340 to nomineeship.

Honorary fellowship recipients were Rt. Rev. Msgr. John G. Fullerton, director of Catholic Charities for the Archdiocese of Toronto; Rear Adm. Lucius W. Johnson (Ret.), San Diego, Calif.; Lucile Petry Leone, assistant surgeon general and chief nurse officer, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.; and William S. Middleton, M.D., chief medical officer of the Veterans Administration, Washington, D. C.



Anthony W. Eckert, director, Perth Amboy (N. J.) General Hospital, was named president-elect of the ACHA at its business meeting. Frank S. Groner, administrator, Baptist Memorial Hospital, Memphis, became president, succeeding Arthur J. Swanson, chairman, Ontario Hospital Service Commission.

Other officers are Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville, Ind., first vice-president; A. A. Aita, administrator, San Antonio Community Hospital, Upland, Calif., second vice-president.

Outgoing president Swanson announced that the ACHA will hold a special three-day educational conference in commemoration of the College's 25th anniversary in February of next year.

Above, left: Participants in program on "Asiatic Influenza: Its Impact on Hospitals" were (l. to r.): O. G. Kennedy, general manager, Lehn & Fink Division, Lehn & Fink Products Corp.; George C. Schicks, Sc.D., director, St. Barnabas Medical Center, Newark, N. J.; Morton Klein, Ph.D., professor of microbiology, Temple University School of Medicine, Philadelphia; and Carl W. Walter, M.D., associate clinical professor of surgery, Harvard Medical School, Boston.

Effective Sanitation Best Weapon Against Asian Flu

Sanitary Sins at Fault In Virus Transmission

Home is the best place for someone with Asian flu, but if he winds up in the hospital, effective environmental sanitation is the best weapon against complications as well as spread of the infection, according to speakers at a discussion on "Asian Influenza: Its Impact on Hospitals," presented by Lehn & Fink Products Corp.

The speakers were Morton Klein, Ph.D., professor of microbiology, Temple University School of Medicine, Philadelphia, and Carl W. Walter, M.D., associate clinical professor of surgery, Harvard Medical School, Boston.

Most influenza viruses are probably transmitted indirectly, rather than directly from one person to another, Dr. Klein pointed out. For instance, viruses may be shed on floors or bedding.

The "greatest of sanitary sins," Dr. Klein continued, is to sweep a floor with a dry broom, instead of mopping it with a germicidal solution.

Dr. Walter, who also stressed the need for mopping with a germicidal solution, emphasized that floors should be systematically flooded with a measured quantity of germicidal solution and a wet pick-up vacuum technic used to leave the floor clean, dry, and disinfected. The janitor's closet may be another repository of infection, spread by dirty mop heads taken from stagnant mopping solutions which are never changed. A fresh mop head should be used daily.

Other recommendations by Dr. Walter included:

—Look for evidence of vicarious ventilation — doors propped open, for example, making stairwells tunnels for air currents which may transport bacteria from contaminated to otherwise clean areas of the hospital.

—Check filters and humidifiers in the air-conditioning system.

—Sterilize bedside water carafes daily and fill them directly from the tap. Use clean ice which is handled with a "no-touch" technic. Bedside carafe water, Dr. Walter said, is "pretty much diluted sewage."

—Find out how often blankets are laundered. Abandon common stocks of blankets. Every patient should have his own individual blanket which is clean when it is given to him and is laundered after his discharge, before it is used again.

—Check the laundry. Make sure that no soiled linen is allowed to accumulate, so that bacteria are not allowed to thrive.

—Set vermin traps.

—Make bacteriological cultures a regular part of the hospital's program.

Asian flu itself is usually not lethal, but when it complicates some other disease, it may be a factor in causing death, Dr. Walter said.

There is no shortage of opinions but a great scarcity of data about Asian flu, commented Dr. Klein. "Is this perhaps a newspaper disease?" Dr. Walter wanted to know.

When the chairman asked for a show of hands by persons who had had experience with Asian flu cases in their hospitals, not one hand was raised.

Hospital Costs Will Continue To Rise, Snoke Predicts

Society Should Assume Cost Of Educating Health Personnel

Hospital costs will continue to rise, reflecting the nationwide problem of inflation and the spiraling wage scales. It is about time that we realize that the situation will not improve even if we ignore it. For example, in many areas, hospital employees' wage levels are still unrealistically low, and consequently lower-cost hospitalization is being maintained at the expense of that "involuntary philanthropist," the hospital employee.

Wages and salaries will have to become competitive in this modern labor market, and hospital costs will inevitably rise. Even in those hospitals in which wages have been increased in an attempt to match the existing community wage scale, there is no possibility of hospital costs leveling off. They are tied too closely to the nationwide problem of inflation.

Widespread medical and hospital insurance offers the only hope for paying for medical and hospital care for the vast majority of the population of this country. It is very important that the insurance programs be patterned so that the subscriber does not need to be in a hospital bed in order to benefit from his policy.

A limited number of voluntary hospitals have carried the primary burden of the cost and effort of recruitment and education of nurses, and, to a lesser degree, of other paramedical groups. Because recruitment of health personnel is a national problem of great urgency, society in general should assume the expense of recruitment and education of health personnel through local, state, and national tax funds, or by spreading the cost through health insurance to a maximum number in the population. —**Albert W. Snoke, M.D.**, Retiring President, American Hospital Association, and Director, Grace-New Haven Community Hospital, New Haven, Conn.

President-elect Tol Terrell, San Angelo, Tex., and Mrs. Terrell greet guests in receiving line at president's reception and tea dance, given in honor of incoming president and held on first evening of convention.

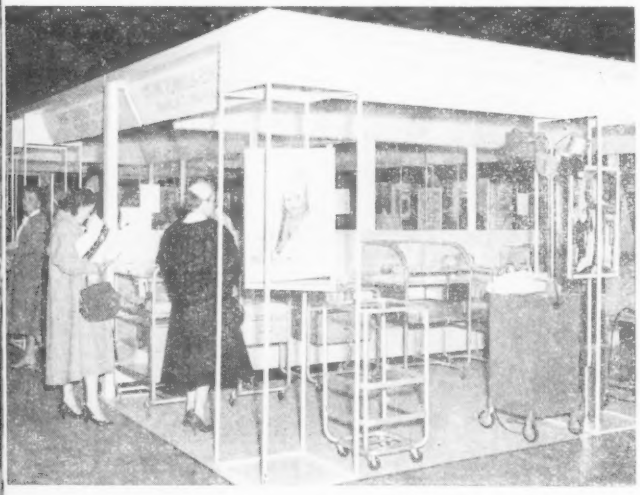
Sister M. Maureen, R.S.M. (facing camera), administrator, Mercy Hospital, Bay City, Mich., and Sister M. Maurita, R.S.M., administrator, St. Mary's Hospital, Grand Rapids, Mich., talk with A. H. Roessling, Detroit, architect.

Discussing Wisconsin affairs at president's reception are H. M. Coon, M.D. (l.), administrator, Milwaukee County Hospital, and John W. Rankin, director, Milwaukee County Institutions and AHA delegate at large, Wisconsin.

Major James W. Hice, administrator, USAF Hospital, Schilling Air Force Base, Kans., gets acquainted with Elsie Gravatt, nursing supervisor, and Helen L. Price (r.), assistant supervisor, both of Camden County General Hospital, Lakeland, N. J.

Stuart Aldhizer, administrator, Lewis Gale Hospital, Roanoke, Va., and alternate delegate to AHA, Virginia, waits with Mrs. Aldhizer for friends at reception and tea dance, one of convention's entertainment highlights.

Above: Thirty-two naval medical officers from foreign countries, in the United States for a special course at the Naval Medical Center, Bethesda, Md., came up to Atlantic City for one day of the meeting. Above (l. to r.): Carlos Cepeda, Chile; Akira Takagi, Japan; Virgilio Zamora, Philippines; Antonio Venegas, Chile; Avelino Tayag, Philippines, and L. E. Titus, Haiti.



Above: Visitors to Infant Formula Center view demonstrations of latest technics in infant feeding in group exhibit prepared by seven companies. Center, complete with nursery, processed 600 complete assemblies of formula daily. Below: Hospital personnel choose reprints of HOSPITAL TOPICS articles of special interest to their departments in TOPICS booth at convention.

Comprehensive, One-Package Policy Greatest Need in Health Insurance

Protection Against Catastrophic Illness Should Not Be 'Hedged with Limitations'

The single greatest need in health insurance is for the comprehensive one-package insurance policy, combining prepaid medical care and health insurance.

In addition to providing greater protection, such a policy encourages the individual to seek preventive medical care. If periodic health examinations can be covered in the average health insurance policy, we will have much more incentive to seek medical counsel with reasonable regularity.

Although the lack of actuarial data may retard the development of this kind of coverage, I believe both the insurance industry and the public will receive benefits from it which now seem almost visionary. When that day comes, health insurance will be firmly established as a reliable and predictable source of hospital income.

Protection against catastrophic illness, so far very limited, is greatly needed, and it must not be hedged about with limitations of benefits to specific categories and cancellation clauses.

In discussing payment for health services by government, we must recognize two basic facts:

First, it is now generally accepted that the health of our people is a major national resource and that the government, therefore, has a direct responsibility for the health of everyone.

Second, federal government funds should be employed to stimulate the expenditure of funds from the states, communities, and private sources. The Hill-Burton program is an excellent example of this principle.—**Rep. John E. Fogarty**, 2nd District, Rhode Island.

Accreditation Program Charts Needs in Nursing Schools

Opportunity Provided For Self-Evaluation

The purpose of the nursing school accreditation program is to give schools an opportunity for self-study and self-evaluation so that each school can decide for itself how best to improve its program. The accreditation program has devised criteria to provide a standard definition of what constitutes good nursing service, since different hospitals have different concepts.

When a hospital applies for accreditation to the National League for Nursing, its strong areas are measured against the needs for improvement. Then if the application is approved, the school will be visited within the next two years.

When a visit is scheduled, the school should make every effort to be prepared by having the faculty available and facts and information readily at hand. Two visitors will come—one a representative of the NLN and one a nurse from the regional area of the school.

The visitors also perform the services of a consultant. Their purpose is to validate the application and amplify or clarify questions posed by the board rather than to provide inspection criticism. Their opinions are given to the school in the form of advice.

Accreditation is only valuable if there is cooperation on the application between nurses and administration, if the hospital understands what accreditation means, and if the school really wants it. The nursing service must function under the framework of the hospital and must subscribe to its philosophy. The school must know the aims and objectives of the institution.

The hospital must not only know the goals and accom-

plishments of the accreditation program but must be ready to analyze itself before the application and after approval.

Eighty-five percent of nursing students are in hospital schools. Hence, endorsement by the hospital of the goals of the accreditation program can help in providing students with a good training program as well as in preparing good bedside nurses.

If an application for accreditation is not approved, it should be remembered that the list of improvements recommended is sent to the school, and that the school can reapply the next year.—**Rev. John J. Flanagan, S.J.**, Executive Director, The Catholic Hospital Association, St. Louis; **Helen Nahm, R.N.**, Associate General Director, National League for Nursing, New York City; **Mildred E. Schwier**, Director, Department of Diploma and Associate Degree Programs, National League for Nursing, New York; **Dorthea I. Glasoe**, Director of Nursing, Northwestern Hospital, Minneapolis.

Executive Functions Outlined In Management Sessions

Organization, Personnel Problems Discussed

Problems of personnel, executive organization, and administrative structure formed the basis for a series of highly successful symposiums on management during the AHA convention in Atlantic City. An innovation in programming, the daily sessions, each with a speaker and a panel of discussants, emphasized the practical aspects of hospital management.

General topics of the four sessions included executive behavior in an organization; the human equation in management; new concepts and technics of administration; and decision-making. Major points developed in the series were:

The individual employee cannot be isolated as a personality so that he is one type of person during his working day and another type during his non-working hours. He often brings his personal problems to his work and, conversely, his job problems to his personal life.

Problems of administration are largely problems of human beings. Consequently, the job of management is to create understanding between management and personnel and between individual employees.

Lack of skill is only one major problem in securing and retaining personnel. Studies of why people lose their jobs indicate that other major problems are lack of character, disloyalty, immorality, and laziness.

A major function of management is communication. Successful communication could be defined as "assuring that each person knows the rules and understands what is expected from him."

Often nontechnical employees identify with professional groups within the hospital, such as nurses or medical technologists, instead of with the organization itself. This can result in a division of loyalty and often can cause problems to management. Although good internal relationships within an organization improve coordination and job performance, the employee's primary identification must be with the over-all organization. Reduction of professional identification in favor of identification with the employer organization may be achieved by increasing the status of nontechnical jobs within the organization and in the community.

The pattern of personnel organization often affects the interrelationship of employees. The two major types of organization can be classified as inner-directed and outer-directed.

Strolling along the boardwalk was, as usual, one of the most popular pastimes for conventiongoers. Above: Two sisters stop to examine picture postcards. Below: Bernard L. Fuss (l.), assistant director, Beth Israel Hospital, New York City, and Louis Braun, administrative assistant, Jewish Hospital, Brooklyn, N. Y., look over souvenir collection at another boardwalk shop.

Below: Herbert Abramson, assistant director, Long Island Jewish Hospital, New Hyde Park, N. Y., studies scale model of Davis Foundation Clinic, Marion, Ind., at convention architectural exhibit. Over 55 hospital architectural projects, representing 37 architectural firms, were displayed from all parts of the country.

Top: Morris Rothenberg, senior architect, New York City Department of Public Works, and Mrs. Rothenberg look over program at luncheon for international guests. Center: Vane M. Hoge, M.D. (r.), Washington, D.C., assistant surgeon general, United States Public Health Service, emphasizes a point to Laurence U. Chandler, Stockley, Del., business manager, Hospital for Mentally Retarded, at luncheon.

Left: Having an informal chat before sitting down at luncheon for international guests are (l. to r.) Matthew E. George, coordinator of supply distribution and utilization, The Seton Institute, Baltimore; Mrs. John J. D'Urso, Methuen, Mass., board member, Auxiliary, Bon Secours Hospital, and Dr. D'Urso, president, medical staff, Bon Secours Hospital.

The inner-directed organization emphasizes the methods of internal operations and systems. The model is the machine with each of its cogs functioning in a carefully defined way. No deviation is permitted. Close supervision is required.

This type of management creates many levels of supervision. Emphasis is on performance within the system rather than on the over-all objective. It is easy in this organizational pattern for system to become an end in itself rather than a means to an end.

Outer-directed organization concentrates on the objective rather than on the means. Each member of the organization is imbued with the importance and spirit of the mission. Strict organizational lines are not established and enforced.

The characteristics of outer-directed organization are: decentralization, including that of decision-making, overlapping of job responsibility, and the crossing of job lines to accomplish the task; less typing of employees so that even top executive responsibilities may be interchangeable, and a greater opportunity for employees to expand within their job assignments.

REVIEW PERFORMANCE

When the number of high-level or intelligent employees is large, the outer-directed organization will probably be effective. When the majority of personnel are in the lower educational and intelligence levels, it is more difficult to make them responsive. As a consequence, the inner-directed organization may be more effective.

Administration must constantly review performance. This can be done by personal review, by reports, or by statistical evaluation. The last is the most economical and objective method of evaluation.

Perhaps the most common usage of statistical evaluation is for cost accounting. There are, however, many other applications of statistics which are useful in measuring the effectiveness of management. In addition to evaluating personnel, statistics can be used for expenditure control, through budget preparation and reports, and for inventory controls.

The executive must make decisions from ambiguous and sometimes conflicting data. The executive decision should be made after discussion with subordinates involved. It should be definitive and specific.

Decisions made in hospitals are either tactical in nature —every-day decisions, or strategic—decisions of planning and policy. When strategic decisions are based on a series of smaller, day-to-day decisions, care must be taken to assure that these smaller decisions have not developed an adverse trend which will conflict with established policy of the organization.

SHOULD EVALUATE SOLUTION

Even after the best solution to a problem has been determined, it should only be used after it has been evaluated by the following criteria: 1. the risk it involves; 2. the economy of effort it introduces; 3. its timing; 4. the limitation of resources.

Speaking at the first symposium on executive behavior in an organization was Kenneth McFarland, Ph.D., educational consultant and lecturer for General Motors, Topeka, Kans., who discussed "Management and the Executive." The session moderator was Stanley A. Ferguson, director, University Hospitals of Cleveland, with a panel of Ted Bowen, administrator, The Methodist Hospital, Houston, Tex.; Richard O. Cannon, M.D., director, Vanderbilt University Hospital, Nashville, Tenn.; and Richard T. Viguers, administrator, New England Center Hospital, Boston.

"Effective Leadership Through People," discussed by David G. Moore, professor of management, College of Business and Public Service, Michigan State University, East Lansing, highlighted the symposium on the human equation in management. Moderator of the session was J. Milo Anderson, administrator, Strong Memorial Hospital, Rochester, N. Y., with a panel including Sidney Lewine, director, Mount Sinai Hospital, Cleveland; Walter J. McNerney, director, Course in Hospital Administra-

Above, left: Among the visitors at luncheon for international guests were Shosaku Numa, M.D. (l.), post-doctoral research fellow, Harvard Medical School, and Shozo Numa, M.D., director, Prefectural Amagasaki Hospital, Amagasaki, Japan, and official representative, Japanese Hospital Association. Above, right: Meeting informally at luncheon, immediate past president of AHA, Ray E. Brown, superintendent, University of Chicago Clinics, poses with incumbent president Albert W. Snoke, M.D., New Haven, Conn.

tion, University of Michigan, Ann Arbor; and Boone Powell, administrator, Baylor University Hospital, Dallas.

At the symposium on new concepts and technics of administration, W. Allen Wallis, dean, School of Business, and professor of statistics and economics, University of Chicago, spoke on "Statistics as a Tool of Management." Panel discussants were John P. Garrison, assistant administrator of medical institutions, Highland-Alameda County Hospitals, Oakland, Calif.; Herluf V. Olsen, professor of business economics, The Amos Tuck School of Business Administration, Dartmouth College, Hanover, N.H.; and James W. Stephan, associate director, Course in Hospital Administration, University of Minnesota, Minneapolis. Ray E. Brown, superintendent, University of Chicago Clinics, was moderator.

At the second symposium on executive behavior in an organization, Richard D. Vanderwarker, vice-president and general manager, Memorial Center for Cancer and Allied Diseases, New York City, talked on "Decision-Making." The panel, moderated by Robin C. Buerki, M.D., executive director, Henry Ford Hospital, Detroit, consisted of James P. Dixon, M.D., commissioner, Department of Public Health, City of Philadelphia; Carl C. Lamley, executive director, Stormont-Vail Hospital, Topeka, Kans.; and Matthew F. McNulty, Jr., administrator and professor of hospital administration, University Hospital and Hillman Clinic, Birmingham, Ala.

More Acute Need for Chronic Care Facilities Foreseen

Expansion of Health Insurance Coverage Urged to Help Solve Problem

The chronically ill patient is a neglected patient from every standpoint at present. The majority of nursing homes, which care for most such patients, lack adequate funds and technical personnel to provide all the facets of service necessary.

The dilemma is due in part to apathy of medical, hospital, and nursing personnel who have been preoccupied with caring for the acute patient.

Chronic illness constitutes today's number one health problem. One of every three Americans over the age of 45 has a chronic disease. If the population increases at the expected rate, the demand for facilities to provide long-term care for the chronically ill will become even more acute in the future.

If nursing homes are to provide adequate and appropriate care for the chronically ill at a reasonable cost, three needs must be met. First, capital funds must be raised for construction of new facilities and expansion of existing ones. Adequate revenue must be available for operation of the plant and purchase and maintenance of equipment. Finally, properly trained personnel are necessary to provide total care of the patients.

Some capital funds have been obtained through the federal and state governments, but at present these are not adequate to meet the demand for facilities. Expansion of prepaid health insurance coverage is one solution to the problem of meeting the cost of long-term care. Programs of expanding insurance coverage are under development and are gradually meeting the requirements. Vigorous efforts must be made to attract people to this field of service to provide an adequate supply of technical personnel.

Efforts are being made to improve the care of patients in nursing homes through closer cooperation with area hospitals. Many experts advocate construction of new nursing homes as wings or additions to existing hospitals.

Physical and recreational therapy and rehabilitation activities are being started while the patient is still in the acute hospital, resulting in his arriving at the nursing home in better health.

Integration and cooperation among all the resources of the community and in particular, between hospital and nursing home personnel are necessary to elevate the standards of patient care in existing facilities.—**Donald M. Rosenberger,** Director, Maine Medical Center, Portland, Me.; **Paul R. Hanson,** Director, Emanuel Hospital, Portland, Ore.; **B. W. Mandelstam, M.D.,** Administrator, Mount Sinai Hospital, Minneapolis.

Survey Shows Red Cross Still Largest Blood-Collecting Agency

Hospital Programs Combined, However, Collect More Than Red Cross

A report on a survey of the Joint Blood Council, soon to be published in the *Journal of the American Medical Association*, shows that an estimated 4,585,000 pints of blood were given in transfusions in the United States in 1956, to 2,000,000 patients. About 5,000,000 pints were obtained from donors.

Mid-morning coffee hour for wives of convention registrants attracted many during meeting. Above, left (l. to r.): Mrs. Warren Simonds, wife of assistant administrator, Pontiac (Mich.) General Hospital, stops on stairs with Mrs. Fred Foster and Mrs. Joseph Degen, whose husbands are both assistant directors, Massachusetts General Hospital, Boston. Center: Mrs. George E. Cartmill, wife of director, Harper Hospital, Detroit, sits down during coffee hour to read convention bulletin with Mrs. Oliver G. Pratt (l.), wife of executive director, Rhode Island Hospital, Providence; and Mrs. Anthony J. J. Rourke, New Rochelle, N. Y., wife of hospital consultant. Right: Making plans to attend afternoon meeting are (l. to r.) Mrs. Walter B. Rice, Kingston, Pa., and Mrs. Walter S. Pugh, Wilkes-Barre, Pa., whose husbands are, respectively, assistant manager and manager, VA Hospital, Wilkes-Barre; and Mrs. J. W. Beaton, R.N., MacDill Air Force Hospital, and wife of business manager, Southwest Florida Tuberculosis Hospital, Tampa.

Where did the blood come from? The Red Cross, which supplied 37.9 percent, is still the largest single blood-collecting agency. But hospitals collecting blood for their own use provided 36 percent of the total supply, and four percent came from other hospitals. Thus, hospital self-help programs provided more than the Red Cross. Community blood banks supplied 9.5 percent; commercial blood banks, 10 percent, and independent donors, two percent.

The repeat donor is saving the lives of individuals who need blood. What we lack is organiza ion of donors. Once we achieve that, our procurement problems will be solved.—**Frank E. Wilson, M D.**, Executive Vice-President, Joint Blood Council, Inc., Washington, D.C.

Below: New Fellows of American College of Hospital Administrators, Meyer J. Gill, director, Beth Israel Hospital, New York, and Arthur Allen (r.), superintendent, Rockaway Beach (N.Y.) Hospital, read certificates conferred during College convocation.

Voluntary Donors Maintain Blood Program; More Organization Needed

Walking Blood Bank Offers Great Potential for Obtaining Blood

Present cost to the patient for blood ranges from an absolute minimum to what might be called a fantastic figure. There should be no profit in blood.

It it were not for the voluntary donor, we would not have any blood. Technical problems of blood storage and use will probably be overcome much faster than the procurement personnel will overcome the need for voluntary donors.

There is a greater potential for obtaining more blood by establishing walking blood banks and providing free typing in connection with them—in advance of donation. The walking blood bank is a very successful mechanism if the right kind of persons are behind it. The cost of maintaining a pool of donors is low.—**G. D. Cummings, M.D.**, Director, Division of Laboratories, Michigan Department of Health, Lansing, Mich.

Panel Discusses Provision of Drugs After Normal Pharmacy Hours

Emergency Drug Cabinet Set Up For Nurses at Hartford Hospital

The night nursing supervisor answers calls for pharmacy service between 5 p m. and 9 a.m. at the Hartford (Conn.) Hospi al, an 806-bed, 150-bassinet general hospital. A doctors' office connected to the hospital provides office space for 119 physicians and makes late evening rounds convenient for the doctors as they leave for the day. These late rounds were arousing demands for various medications not kept in the ward stocks.

A two-week study revealed that the night supervisor was spending an average of 1.94 hours a day seeking medications in the pharmacy. The bulk of the demands came between 5:30 and 9:30 p.m. Because of the feeling that too much nursing time was being spent on these pharmacy duties, a committee was organized to study and suggest a solution for the problem.

After a three-month study of these evening requests,

Above, left: Major General Howard McC. Snyder (l.), Washington, D.C., physician to the President of the United States, and speaker at Federal Hospital Executives luncheon, is greeted by (l. to r.) William S. Middleton, M.D., Washington, D.C., chief medical director, Veterans Administration; Edwin L. Crosby, M.D., Chicago, executive director, AHA; and Silas B. Hays, M.D., Washington, D.C., Surgeon General, Department of the Army. Above, right: Tol Terrell (l.), new AHA president, and Dr. Hays chat before luncheon with Fred A. McNamara, Washington, D.C., chief, Hospital Branch, Bureau of the Budget.

the pharmacist organized an emergency drug cabinet stocked with drugs most commonly ordered in the off hours. Physicians were kept informed of drugs readily available to the nurses and urged to limit their requests to this stock except in cases of extreme emergency. The nursing personnel find the cabinet a convenience and time-saver and at the same time feel more secure in handling drugs which have been packaged and labeled by the pharmacist.—**Mrs. Marion Kent, R.N.**, Night Supervisor, Hartford (Conn.) Hospital.

Special Area in Pharmacy Meets Needs at Madison Hospital

In the **Madison (Wis.) General Hospital**, a 360-bed, 44-bassinet general hospital with a medical staff of 297, access to the pharmacy is forbidden except to regular personnel. To care for drug needs during the evening and night hours, an 8 x 12 area adjacent to the pharmacy has been arranged and fitted.

The key to this room, used by the nurse supervisors, conforms to no other space in the pharmacy. The room is fitted with a refrigerator, cabinet, shelf space, desk, telephone, reference books, and catalogues. During regular hours, the room is used as the main pharmacy office, and the facilities and reference material are used by house officers, student nurses, and medical staff.

Selected drugs representing the regular pharmacy stock are pre-packaged, sealed, labeled, and catalogued and sectionalized according to the route of administration. The nursing staff, when filling orders, can select drugs from an alphabetized reference book which lists the drug by name and includes information on dosage, route of administration, etc. Requisitions are filled out and left in the pharmacy to be handled in routine fashion the following day and to serve as an index of stock to be replenished.

Labeling is exact, and directions are specific and simple to follow. Bottles are sealed, signifying to the nurse that the drug has been prepared by the pharmacist and has not been opened for any purpose.

In addition to this "night drug room," each nursing station is provided with a plastic box which contains the drugs and equipment for emergency injections. Drugs are arranged alphabetically for quick selection, and an inventory and directions for administration are posted in the cover of the box.

With this arrangement, the nurse does not have to enter the pharmacy proper, and is not involved in counting, measuring, and pouring. The cataloguing and sectionalizing make for easy, quick, safe selection.—**R. G. Henry**, Chief Pharmacist, Madison (Wis.) General Hospital.

Every Hospital Can Conduct Research in Social Medicine

Studies Can Be Made Relating Disease to Social Background

The hospital, if it is a focus for health activities in the community, offers many opportunities for research in social medicine. Research may be considered under four headings:

1. Studies in the social epidemiology of disease—studies

Above: After ACHA convocation Mother Jeanne-Mance Bertrand (l.), assistant administrator, University of Montreal (Que.) Hospital, shows fellowship certificate to membership nominees (l. to r.) Sister Martha Gage, assistant administrator, Degoesbriand Memorial Hospital, Burlington, Vt.; Sister M. St. Paul, administrator, St. Joseph's Hospital, Brantford, Ont.; and Sister Mary Grace, administrator St. Joseph's Hospital, Hamilton, Ont. Right: Gathered before federal luncheon were (l. to r.) Ensign Ephraim E. Fowler, U. S. Naval Hospital, St. Albans, N.Y., Lt. Lloyd M. Ash, and Lt. Kenton Hypes, Jr., Naval Medical Center, Bethesda, Md.

of the incidence of specific diseases, relating the diseases to the social background of the individual patients. Studies of this type may be done in any hospital that obtains and files records of its cases.

2. Studies of receipt of health care in relation to needs. Such studies are important in planning the community's medical and related services. Other subjects which might come into this category are the kinds of patients which go to each hospital in the community and their reasons for selection of their hospitals, and utilization of the hospital in other forms of medical care.

3. Problems in the day-to-day operation of hospitals.

4. Demonstration programs—development of new forms of patient care, such as organized home-care programs; development of new modalities of medical care within the hospital, such as rehabilitation.

Although it may be easier to conduct these projects in a large institution with a large staff, some of them can be done in any hospital.—**Milton I. Roemer, M.D.**, Director of Research, Sloan Institute for Hospital Administration, Cornell University, Ithaca, N.Y.

Social-Service Rounds, Family Health Service Teach Students New Approach

Medical schools have been woefully neglectful about giving some information on the practice of medicine instead of only the science of medicine. How are we going to teach our medical students and some of the coming generations in the health field to adopt this new approach in medical care? Here are some of the efforts we are making in teaching:

1. On all medical wards we have weekly social-service rounds, which really should be called social-medical rounds.

2. In the Family Health Service, families are enrolled as patients for all medical care they may need. A medical student keeps the same families for his third and fourth year and follows his patients, observing not only their illnesses but also the effects of the illnesses on the family. —**Dean A. Clark, M.D.**, General Director, Massachusetts General Hospital, Boston.

Good Communication Plays Role In Maintaining Efficient Food Service

Maintenance Schedules, Requisition System For Repair Needed Even in Small Hospital

Good communications between the dietary, maintenance, and housekeeping departments can solve most of the problems of responsibility for efficient food service. Close cooperation between the departments and a good working relationship can prevent major breakdowns in equipment and insure efficient use of facilities.

A further help to interdepartmental communications is a planning committee including department heads and the administrator. Such committees should have regularly scheduled meetings with planned agendas. Decisions should be put into writing and circulated to all staff members concerned.

Maintenance schedules and a requisition system for equipment repair are worthwhile even in a small hospital. A requisition system gives valuable information on the service record of a piece of equipment.—**Everett A. Johnson**, Administrator, Methodist Hospital, Gary, Ind.; **Charlotte Kaufman**, Director of Housekeeping, Michael Reese Hospital, Chicago; **Leland J. Mamer**, Director of Buildings, St. Luke's Hospital, New York City; **Louise Stephenson**, Director, Department of Nutrition, The New York Hospital, New York City.

Hospital of 1967 Described by Panel

Population Changes Anticipated; Community Services to Expand

What hospitals will be like in 1967 was envisioned by an eight-member panel at the Conference on Hospital Planning, which was attended by an overflow audience of about 1,350 persons.

Projecting themselves into 1967, panel members predicted that the following changes will occur in the next 10 years:

- There will be substantial population changes. The farm census will continue to decrease. The suburban population will increase, while large metropolitan areas will decrease. The proportion of very old and very young will also increase. These changes will have a substantial impact on the disease patterns of the nation.
- There will be a decrease in obstetrics, and an increase in urology, pediatrics, and orthopedics—the increase in orthopedics due to more extensive use of automobiles and helicopters.
- There will be a greater emphasis in the period 1957-67 on prevention of disease and less on institutional care. As a result, day stay will reduce, but admissions will increase.
- The community services offered by hospitals will be greatly expanded. By 1967, hospitals will characteristically include special services for the aged, facilities for the alcoholics and narcotic addicts, and public health and rehabilitation centers.
- Psychiatric problems will increase, but there will be a better understanding of the problems by all elements of the community. There will be fewer large mental hospitals. Psychiatric care will be normally provided in general hospitals.
- Community leadership and trustees in particular will grow in stature and sophistication in hospital problems.
- Private voluntary health insurance will increase in scope and number of persons covered. Health programs for the aged will expand.
- While there will be more effective utilization of personnel, the problems of the administrator will increase. Laboratories will triple in size, and the x-ray department will double. Costs will rise.
- The need for Hill-Burton will be greater than ever. Funds will be needed to convert tuberculosis and pediatric hospitals.
- The number one national problem by 1967 will be disease of the circulatory system.

David B. Wilson, M.D., was chairman of the session, and panel members were Gordon R. Cumming, chief, Bureau of Hospitals, California State Department of Public Health, Berkeley; Reed B. Hogan, administrator, Coahoma County Hospital, Clarksdale, Miss.; Raymond F. Killion, second vice-president, Metropolitan Life Insurance Co., New York City; Jacque B. Norman, vice-president, American Association of Hospital Consultants, Greenville, S. C.; Maurice E. Odoroff, chief, program evaluation and reports branch, Bureau of Medical Services, Department of Health, Education, and Welfare, Washington, D. C.; Eric Pawley, research secretary, committee on hospitals and health, American Institute of Architects; Marshall I. Pickens, director, hospital and orphan sections, The Duke Endowment; and Ray E. Trussell, M.D., executive officer, Columbia University School of Public Health and Administrative Medicine, New York City.

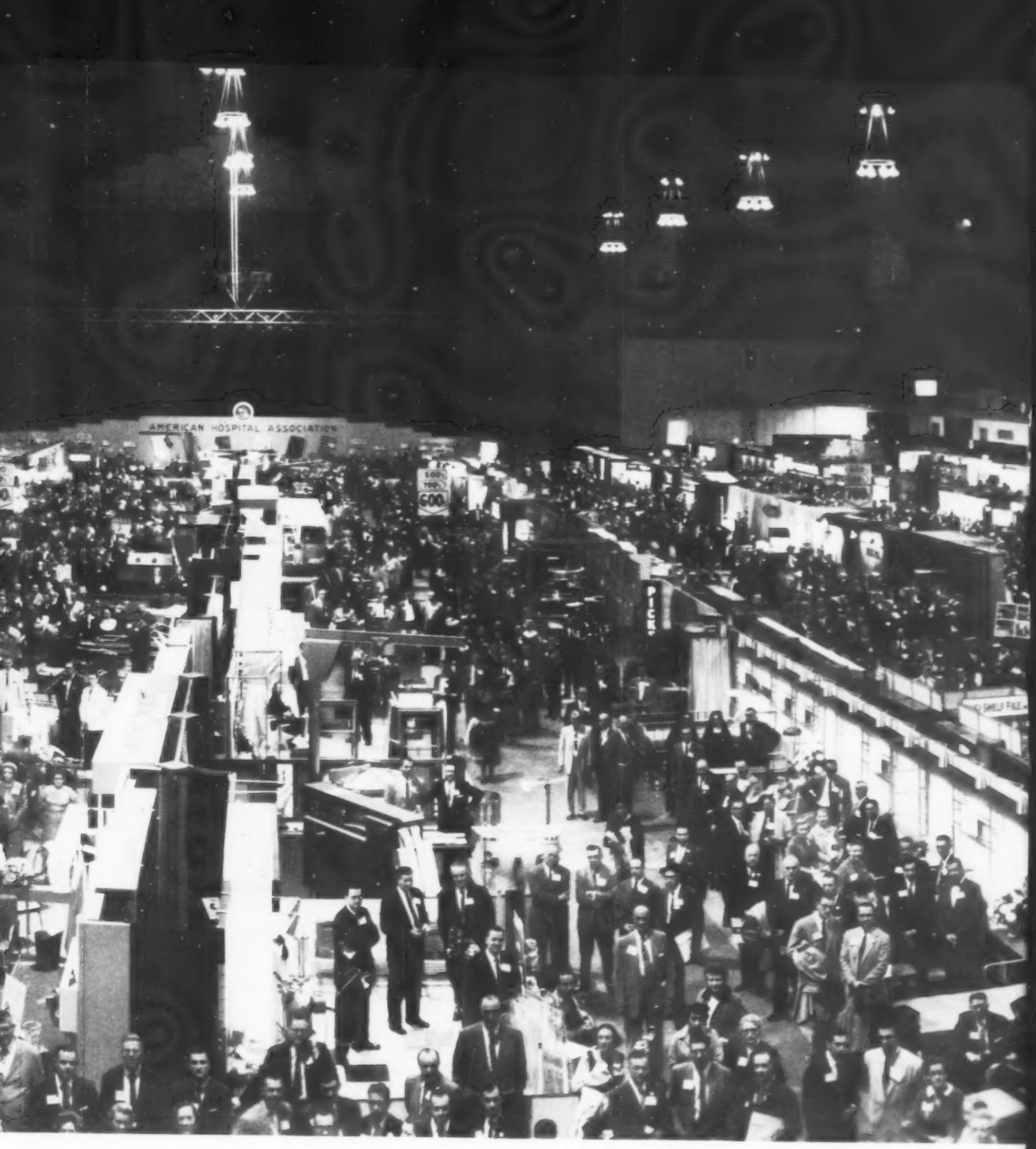
Repre
bert,
(AHA
Robbi

Representing the firms who received the HIA Exhibit Awards are (l. to r.): Ross Hofmann, Southern Cross Mfg. Co.; Harry Gilbert, E. F. Hauserman Co.; Robert W. Burmeister, National Cylinder Gas Co.; J. W. Bamert, Magic Door Sales; Bremen Johnson (AHA); John E. O'Neil, International Nickel Co.; W. E. Smith (HIA), Ted Eckels, Ethicon, Inc., and C. L. Smith, McKesson & Robbins.

For

For a "You Are There" TOPICS

see r



PICS picture report on the latest

e reverse side of this 5-page in

For a "You Are There" TOPICS

see r

PICS picture report on the latest

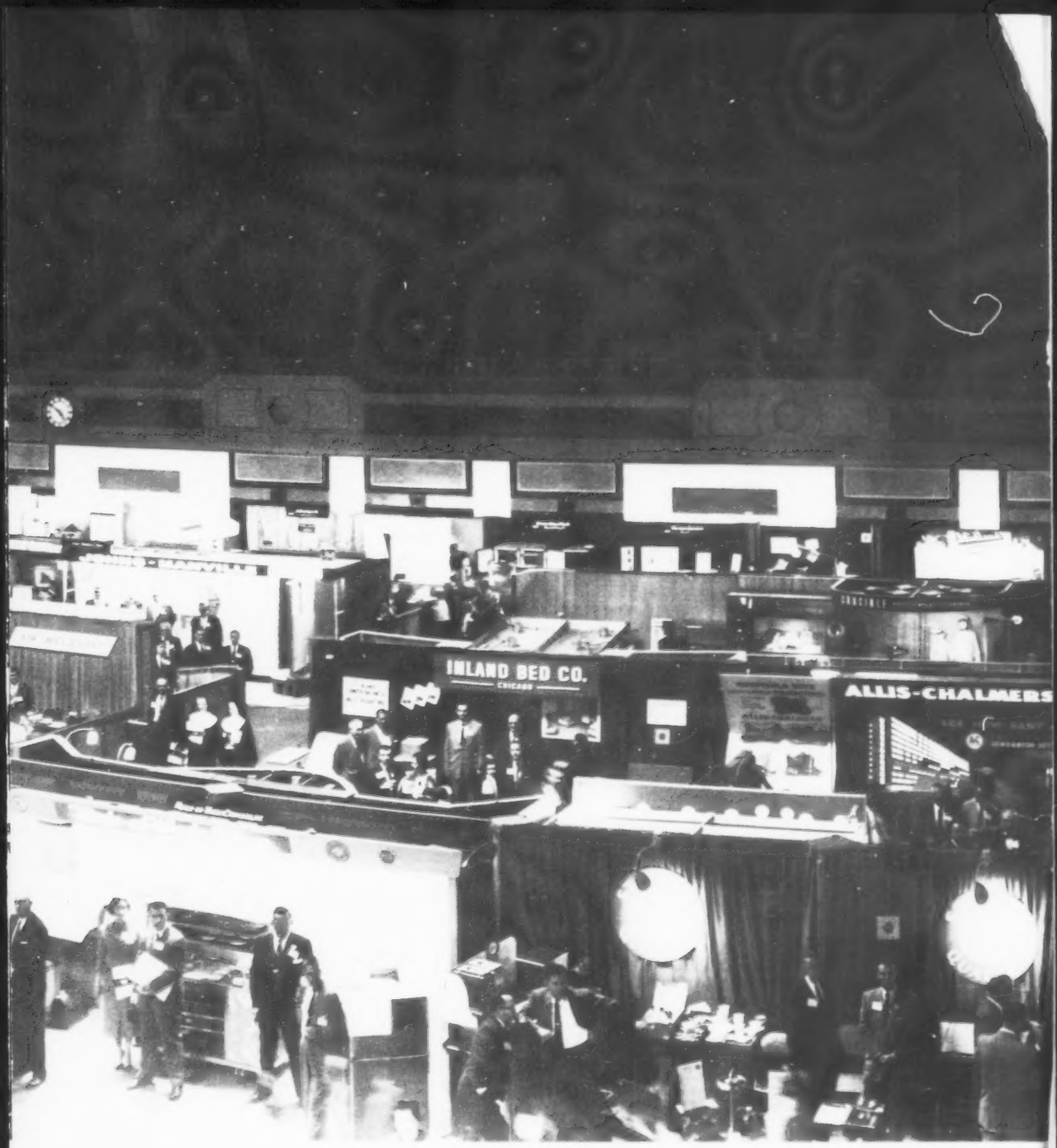
e reverse side of this 5-page in

ICS picture report on the latest

e reverse side of this 5-page ins

est in products and services—

insert



HOSPITAL INDUSTRIES ON PARADE!

To see 5-page picture spread of the panorama which was the exhibition hall at the AHA convention in Atlantic City, pull out this folded insert.

PULL HERE

HOSPITAL INDUSTRIES ON PARADE

AHA Product Report

Photos by HOSPITAL TOPICS

Officers of the Hospital Industries Association, photographed at the organization's breakfast meeting during the American Hospital Association meeting in Atlantic City, are (l. to r.): Rollie Simons, Ethicon, Inc., vice-president and president-elect; Harris L. Willets, C. R. Bard, Inc., new president; James G. Dyett, Hard Mfg. Co., outgoing president; and Robert H. Brown, Becton, Dickinson and Co., vice-president and treasurer.

Above: Aeroplast Corp. displayed a new surgical dressing that is tinted yellow for controlled application to a definite area. Wally Apgar (l.), sales manager, tells John Wilcox, assistant administrator, House of Good Samaritan, Watertown, N.Y., and Herman W. Fibiger, administrative assistant, Crouse Irving Hospital, Syracuse, N.Y. how the dressing can be sprayed directly onto a lesion. AHA-a.

Above: James Carr, administrator, Memorial Hospital, Casper, Wyo., and W. B. Coburn, administrator, Bethany Hospital, Kansas City, Mo., stop at the exhibit of the Rehabilitation Products Division of American Hospital Supply Corp. Le Roy Meyer (r.) tells them about the automatic toilet seat called Washex. Seat uses a warm spray of water for washing and warm air for drying. AHA-b.

Below: Sister Charles Cecilia (l.) and Sister Mary Louise, both of St. Joseph Hospital, Augusta, Ga., ask Agnes Zizak, of Professional Tape Co., about autoclave labels that can be reused five times. AHA-c.

Below: The new Dixie Cup line for bedside water service and between-meal nourishment was explained by L. W. Escenbach (center) to George A. Miller (l.), administrative assistant, and Burton Gottlieb (r.), both of Monmouth Memorial Hospital, Long Branch, N.J. AHA-d.

Some of the newest items from the meeting are featured in this special section. Additional AHA product news will appear in the Buyer's Guide section of the November issue of HOSPITAL TOPICS.

Left: Top to bottom: Lt. Shun-Te Wang, medical service corp., first naval district, Taipei, Taiwan, and Su Ching-Yang, M.D. (r.) commander, Chinese Navy, Taipei, Taiwan, look at the jumbo circle filter in the Foregger booth. George Pickering tells them the filter is reversible for more efficient absorption and economy of operation. AHA-e.

The Para-Patch permanent marking system was inspected by H. E. Rice, business manager, Porter Sanitarium and Hospital, Denver, Colo., and Mrs. Rice, auxiliary member. Andrew Zimet (r.), representing Anglo Chemical and Rubber Corp., tells them how the heat-adhesive patches, in different colors, can be fused to uniforms and linens. AHA-f.

Three generations of the Hatfield family stop to see the medicine and syringe tray held by Helen Botdorf, Meinecke & Co., Inc. John N. Hatfield (center) is treasurer, AHA; his son, John N. Hatfield II, is a staff representative for the association. John N. Hatfield III starts the convention circuit at a tender age, just as his father did. AHA-g.

Premiered at the AHA convention was the D-H power unit. Virginia Page, advertising representative, HOSPITAL TOPICS, asks Robert H. Lee, general manager, Doyle Hospital Products, about the unit, which enables either patient or nurse to control and adjust any hospital bed automatically by pushing a button. AHA-h.

Above: The simplified design of the surgical glove tester of the John Bunn Corp. interests Marguerite E. Kane, R.N., Nyack (N.Y.) Hospital. Julius Bienstock, district sales manager, explains operation. AHA-i.

Be sure to see REVERSE si

f the newest items from the meeting are
d in this special section. Additional AHA
news will appear in the Buyer's Guide
of the November issue of HOSPITAL
S.

FOR FURTHER DATA ON ANY OF THE PRODUCTS FEATURED ON THESE PAGES, JOT NUMBERS ON MARGIN OF BUYER'S GUIDE CARD OPPOSITE PAGE 72, THIS ISSUE.

p to bottom: Lt. Shun-Te Wang, medical ser-
., first naval district, Taipei, Taiwan, and Su
ang, M.D. (r.) commander, Chinese Navy,
Taiwan, look at the jumbo circle filter in the
booth. George Pickering tells them the filter
ible for more efficient absorption and economy
tion. AHA-e.

ra-Patch permanent marking system was in-
by H. E. Rice, business manager, Porter San-
and Hospital, Denver, Colo., and Mrs. Rice,
member. Andrew Zimet (r.), representing
hemical and Rubber Corp., tells them how the
esive patches, in different colors, can be fused
rms and linens. AHA-f.

enerations of the Hatfield family stop to see
licine and syringe tray held by Helen Botdorf,
e & Co., Inc. John N. Hatfield (center) is
r, AHA; his son, John N. Hatfield II, is a staff
ntative for the association. John N. Hatfield
ts the convention circuit at a tender age, just
ather did. AHA-g.

red at the AHA convention was the D-H power
Virginia Page, advertising representative, HOS-
TOPICS, asks Robert H. Lee, general manager,
Hospital Products, about the unit, which enables
patient or nurse to control and adjust any hos-
ed automatically by pushing a button. AHA-h.

: The simplified design of the surgical glove tester
John Bunn Corp. interests Marguerite E. Kane,
Nyack (N.Y.) Hospital. Julius Bienstock, district
manager, explains operation. AHA-i.

Above (l. to r.): Sister Geraldine Marie, secretary; Sister M. Ethnea, assistant superintendent, and Sister M. Francis Damien, assistant dietitian, all of St. Mary's Hospital, Philadelphia, watch J. T. Tansey, Ohio Chemical & Surgical Equipment Co. open a sterile plastic packet of surgical sutures wound on new Dispenso-reel which prevents tangling and kinking. Needled sutures are packaged on twin reels to prevent dulling of needle points or the cutting of suture strands. AHA-j.

Above: A self-powered food conveyor was introduced by S. Blickman, Inc. at a press breakfast. This Touch-n-Go Foodveyor is a self-powered variable-capacity food conveyor. Examining the push-button control is Mrs. Bessie West, continuing education services director, American Dietetic Association. Bruce Blickman (r.), vice-president, and T. G. Anker, sales manager, hospital division, give her additional information on how the conveyor can be pushed up ramps. AHA-k.

REVERSE sides of these pages for giant

Above: Libraphone introduced "talking books" at the AHA convention. Full-length books, novels, or stories are recorded on 12" marathon-play 16-2/3 rpm phonograph discs by professional readers. Richard C. Foster (l.), assistant administrator, Uniontown (Pa.), Hospital, asks Robert Schramke, sales manager, about the books. AHA-l.

Above: Burton M. Gottlieb (l.), administrative assistant, Monmouth Memorial Hospital, Long Branch, N.J., hears about Cry-o-therm Gas Sterilizer from E. L. Thompson, American Sterilizer Co. development engineer. AHA-o.

Above: A new item for pathological laboratories—the Barnstead paraffin dispenser—was introduced at the convention. The dispenser provides a clean, easy way to maintain a constant supply of melted paraffin on tap. S. Takins (r.), explained it to Daniel N. Finch, assistant administrator, St. Luke's Hospital, Toledo, O. AHA-m.

Above: J. Steiger, sales representative, Harold Supply Co., explains Steriphane System, the technic for packaging and delivering sterile needles and syringes, to Mary Lea Mills, O.R.S., Burdette Tomlin Hospital, Cape May Court House, N.J. AHA-p.

Above: W. J. Miller (l.), assistant superintendent, Cleveland City Hospital, chats with Everett K. Hunt, W. A. Bushman Associates representative, about the resiflex line of disposable plastic tubes. AHA-n.

Above: Winifred L. Hodgkins, associate director of nursing service, Albert Einstein Medical Center, Philadelphia, asks C. R. Randolph, McKesson & Robbins, about the nurses' station unit for drug storage. A maximum of storage room is provided in a minimum of floor and wall space. Locked narcotics cabinet mounted on inside upper door. AHA-q.

ant photo of Convention Hall

Above: The bifurcated A.G. tube for aortic grafts is examined by John F. Wilcox (r.), assistant administrator, House of the Good Samaritan, Watertown, N.Y., as Hamilton Disston, C. R. Bard, Inc. representative, explains how the tubes are fused together to reduce porosity. AHA-r.

Above: Jack Egan (l.), J. J. Egan Co., points out features of the power-driven Ideal Mealmobile to Alex W. Kruger, M.D., manager, VA Hospital, Brooklyn, N.Y. The unit has a built-in beverage dispenser. AHA-u.

Above: Robert E. Sleight (l.), assistant administrator, New England Center Hospital, Boston, tries the new Televoice—the phone dictation system—at the Thomas A. Edison booth, while Martin Flynn explains a way of phone dictation of medical records. AHA-s.

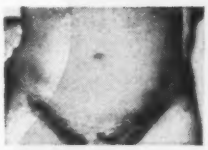
Above: Tom Mulle, Mead Johnson & Co., explains improved blood administration set to Doris Smith, chief laboratory technician, and Ethel M. Turkenkopf (r.), O.R.S., both of East Orange (N.J.) General Hospital. AHA-v.

Above: Colored plaster cast bandages are discussed in the Johnson and Johnson booth by W. M. Guilette (r.), representative, and Reuben H. Graham, purchasing agent, North Carolina Baptist Hospital, Winston Salem, N.C. AHA-t.

Above: E. T. Hamilton (r.) tells Richard K. Fox, administrator, St. Luke's Hospital, Duluth, Minn., that spiral-wound sterile gut is available in a Surgilar® sterile plastic pack. Also on display were Aureomycin surgical dressings. Surgical Products Division, American Cyanamid Co. AHA-w.

Don't miss products on other pages.

new



tinted

AEROPLAST®

Plastic Protective Surgical Dressing

The new yellow tinted Aeroplast dressing is the result of wishful thinking by many surgeons. Even after dressing operation after operation successfully with the original colorless, clear Aeroplast, numerous surgeons "wished" that they had a better visual indication of how much to apply and, also, a better definition of the area dressed.

Yellow tinted Aeroplast fulfills these wishes. It is clearly visible during and after application yet is still transparent.

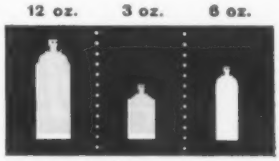
When *tinted* Aeroplast is sprayed onto the wound area, from the recommended ten or twelve inches distance, the immediate appearance of a faint yellow film deters the tendency to overspray and to undesired flooding. In effect, it helps control the aerosol application so that the resulting, thinly applied film dries faster between coats to build an efficient dressing gradually but quickly.

BENEFITS IN PATIENT CARE Clinical advantages remain unchanged: conformity to any body contour with no bulkiness; dependable sterility of dressings which form an impermeable bacterial barrier to outside contamination; antibacterial; simplified postoperative care requiring fewer redressings; transparency permitting visual inspection of healing progress without disturbing or removing dressings; toughness and flexibility allowing easy palpation and osculation; no undesired restriction of respiration or circulation; avoidance of maceration as skin can "breathe"; non-toxic, non-sensitizing, non-allergenic; washable, not dissolved by *any* body exudates.

Rx NO LONGER NEEDED Both tinted and clear Aeroplast are now available without prescription, simplifying distribution to all dressing areas.

Choice of sizes

NEW	**12 oz.** *tinted*	special hospital size, convenient and economical for regular operating room use.
NEW	**3 oz.** *tinted*	handy size for dressing carts, surgeon's office, and to specify for patient use.
	6 oz. *clear*	the original Aeroplast plastic spray-on surgical dressing.



Successful use of Aeroplast dressings is well-documented. Reprints and literature are available on request to:
AEROPLAST CORPORATION
420 Dellrose Avenue, Dayton 3, Ohio

Available through pharmacies and surgical supply dealers
In Canada—Fisher & Burpe, Ltd.

® Brand of Vibesate

Throughout the hospital there are more and more calls for

GANTRISIN *'Roche'*

highly soluble, single sulfonamide

Respiratory Infections	tablets, 0.5 Gm each
Meningitis Surgery	ampuls, 5 cc (2 Gm) and 10 cc (4 Gm)
Urinary Infections	tablets, 0.5 Gm each
Pediatrics	pediatric suspension (raspberry-flavored), and syrup (chocolate-flavored), containing the new, tasteless Gantrisin (acetyl)
Eye, Ear, Nose & Throat Infections	ophthalmic solution, 4%, ophthalmic ointment, 4%, ear solution, 4%, and nasal solution, 4%
Obstetrics & Gynecology	vaginal cream, 10%, in white vanishing cream base
Outpatient Clinic	tablets, 0.5 Gm each

Gantrisin®—brand of sulfisoxazole
Gantrisin® (acetyl)—brand of acetyl sulfisoxazole

Hoffmann - La Roche Inc • Roche Park • Nutley 10 • N. J.

WESCODYNE® cleans as it disinfects

for less than two cents a gallon

FOR ALL AREAS

WESCODYNE is a completely new detergent-germicide that contains amazing "Tamed Iodine"®. Increases germicidal capacity three to four times and offers a much wider range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries.

WESCODYNE is also an excellent detergent as well as a powerful disinfectant. Provides fast cleaning action as it disinfects. A time and labor saver.

... all at a cost of less than 2¢ a gallon at use dilution!

WESCODYNE is nontoxic, nonstaining and nonirritating to the skin when used as directed. Further, it contains an exclusive "built-in" safety feature. In use, its amber color guarantees the presence of germicidal activity. When this color disappears, a fresh solution must be used. You're always sure of germicidal action!

WESCODYNE is recommended for almost any disinfecting procedure. Safe to use. Unaffected by hard or cold water. Leaves no "hospital smell." Send coupon for full information, including recommended surgical, nursing and hospital procedures.

LARGEST COMPANY OF ITS KIND IN THE WORLD

WEST DISINFECTING Company

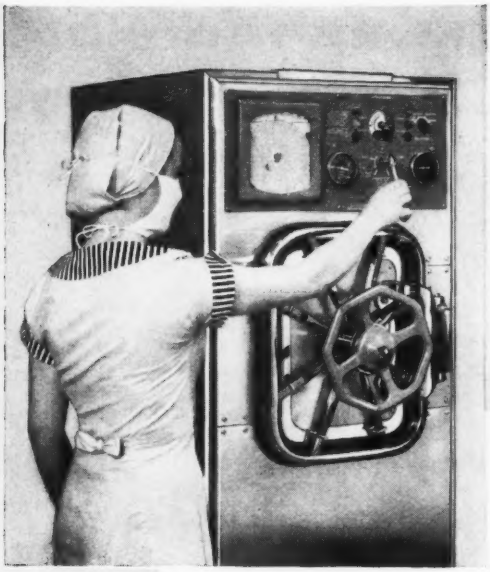
WEST DISINFECTING COMPANY, 42-16 West Street, Long Island City 1, N. Y.
Branches in principal cities • In Canada: 5621-23 Casgrain Ave., Montreal

☐ Please send full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

Name.....

Position.....

Mail this coupon with your letterhead to Dept. 40



Cyclomatic Control eliminates "remembering." "Unitized" Control Panel includes Indicating-Recording-Controlling Thermometer.

the **AMERICAN**

high Speed

PRESSURE INSTRUMENT STERILIZER

12" x 16" x 24"

For All Instrument Sterilizing Procedures:

- 3-minute emergency
- Routine
- Pre-prepared wrapped instruments

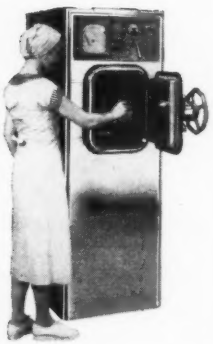
Major Advantages

SQUARE: 12" x 16" x 24" chamber provides 50% more useful space — takes three instrument trays, or basins and other utensils.

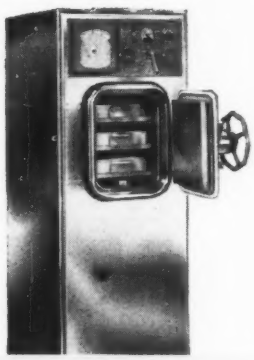
AUTOMATIC: Set-and-forget Cyclomatic Control ends doubts; assures thorough sterilization even under emergency stress.

FAST: Reaches 270° in 45 seconds; holds for 3 minutes; exhausts and dries in 60 seconds for complete emergency cycle of less than 5 minutes.

Write for illustrated bulletin SC-312



12" x 16" x 24" square chamber is large enough for basins and utensils.



Three full size instrument trays with "file drawer" suspension.

COOL • CLEAN • CONVENIENT • SURE

AMSCO

AMERICAN STERILIZER

ERIE • PENNSYLVANIA

Offices In 14 Principal Cities

How Hospitals Can Benefit From Short-Term Trusts

Second in a series on public relations and fund-raising

Hospitals may be able to obtain increased contributions from their loyal supporters by calling attention to the device of the short-term trust. What this device is and how charitable institutions may benefit from its use are explained in this article.

By Bernard Tomson and Herman Jaffe*

• Contributions to hospitals and other qualified organizations undoubtedly could be increased greatly if the tax advantages of the short-term trust method of charitable contribution were more widely known.

The public-spirited citizen who is deeply committed to a particular charity or charities is faced with the dilemma either of restricting his contribution to an amount permitted as a "deduction" or of bearing an unconscionable burden of taxation upon the additional monies contributed.

However, under the 1954 Internal Revenue Code a possible solution to this problem is offered—the use by the taxpayer of a short-term trust. The importance of this solution to organizations which rely upon charitable donations cannot be overemphasized. Unfortunately, this device is not well known, nor often used to advantage.

Under the 1954 Code, income of a trust which is irrevocably payable to certain types of charitable organizations, for a period of at least two years, will be excluded from taxation.

If the taxpayer owns income-producing real property or securities and is willing to divest himself of control of such property for at least two years, he is permitted to contribute such income to charity by the creation of a short-term trust, and the income will be free of taxation.

It is generally provided under Section 673 of the 1954 Code that the grantor of a trust shall be taxable on the income therefrom if he has a reversionary interest in either the corpus or the income which will or may reasonably be expected to take effect within a period of 10 years.

A trust, the corpus or income of which does not revert for 10 years, can be utilized for income-splitting with its consequent tax savings. The income of a trust is either taxable to a beneficiary or to the trust if the income is accumulated.

The first important exception to the 10-year requirement is that relating to charities. The statute provides as follows [Sec. 673 (b)]:

> **"EXCEPTION WHERE INCOME IS PAYABLE TO CHARITABLE BENEFICIARIES."—Subsection (a) shall not apply to the extent that the income of a portion of a trust in which the grantor has a reversionary interest is, under the terms of the trust, irrevocably payable for a period of at least two years (commencing with the date of transfer) to a designated beneficiary which beneficiary is of a type described in Section 170 (b) (1) (A) (i), (ii), or (iii)."**

To qualify under this section, the charitable organization must be a church, a convention or association of churches, a religious order, a hospital, or an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place in which its educational activities are regularly carried on.

The grantor of such a short-term trust is free from taxation of the income during the period of the trust. He has the right to an unlimited charitable deduction for the trust income, and he receives this at the price of only a short-term commitment. The corpus or income of the trust may revert to him after two years without affecting the exclusion of the income for that period from taxation.

In addition, the grantor retains the right to make additional charitable contributions which are deductible under the 20 percent plus 10 percent standard provisions of the Internal Revenue Code.

It is emphasized that the trust income must be irrevocably payable to a *single* designated beneficiary for at least two years, beginning with the date of the transfer, before the grantor can obtain the benefits offered under Section 673 (b). He could not, for instance, take advantage of this provision if income of a trust were irrevocably payable to one charitable organization for one year and to another one for the next year. Nor could

(Continued on next page)

*Mr. Tomson is a member of the legal firm of Bernstein, Weiss, Tomson, Hammer & Porter, New York City, and a member of the board of trustees, North Shore Hospital, Manhasset, L.I., N.Y. Mr. Jaffe, a certified public accountant, is a member of the accounting firm of Jaffe and Felix, New York City.

the section apply if income from a trust were allocated among two or more charitable beneficiaries.

Prior to 1940, the use of a short-term family trust to split income and thereby reduce taxes was a favored device. In that year, the Supreme Court, in deciding the case of Helvering v. Clifford, 309 U.S. 331, declared that if the grantor of a trust is the trustee and the beneficiaries are members of his family, special scrutiny of the arrangement is necessary, to determine whether more than one economic unit actually exists.

In the Clifford case, the grantor irrevocably transferred certain property to himself as trustee for a period of five years, with the income payable to his wife for the duration of the trust. Upon the expiration of the trust, the corpus reverted to the grantor. He also retained substantial powers of control and management of the trust property and its income.

Because of the short duration of the trust, because the beneficiary was the grantor's wife, and because the grantor retained control over the corpus and income, the court concluded that the income of the trust was taxable to the grantor.

The Clifford case was followed by a flood of decisions in which the applicability of the Clifford rule was considered, and in which various considerations of facts were presented. The Commissioner of Internal Revenue adopted a series of regulations effective in 1946 which incorporated the rule of the Clifford case, but these did not completely clarify the situation.

FORMULA ESTABLISHED

Sections 671-679 of the 1954 Internal Revenue Code were adopted by Congress in an effort to establish a specific formula for determining the incidence of taxation of trust income by which grantors could be guided.

Conventional Charitable Contribution

Gross Income	30% Contributed To Charity	Taxable Income	Federal Income Tax	Cash Available To Taxpayer
$100,000	$ 30,000	$ 67,800	$ 31,390	$38,610
200,000	60,000	137,800	82,524	57,476
250,000	75,000	172,800	111,192	63,808
300,000	90,000	207,800	141,582	68,418
400,000	120,000	277,800	203,882	76,118
500,000	150,000	347,800	266,660	83,060

Charitable Contribution by Use of Short-Term Trust

Gross Income	Contributed to Charity from Income of Property Transferred to Short-Term Charitable Trust	Taxable Income	Federal Income Tax	Cash Available To Taxpayer
$100,000	$ 50,000	$ 47,800	$ 19,002	$30,998
200,000	100,000	97,800	52,042	47,958
250,000	125,000	122,800	70,824	54,176
300,000	150,000	147,800	90,558	59,442
400,000	200,000	197,800	132,726	67,274
500,000	250,000	247,800	177,182	72,818

Comparison of Conventional Charitable Contribution and Contribution by Use of Short-Term Trust

Gross Income	Additional Charitable Contribution by Use of Short-Term Trust	Net Reduction Of Income To Taxpayer
$100,000	$ 20,000	$ 7,612
200,000	40,000	9,518
250,000	50,000	9,632
300,000	60,000	8,976
400,000	80,000	8,844
500,000	100,000	10,242

The underlying theme of the code, in determining the taxability of trust income, is the aid given the grantor in making certain that he has divested himself of ownership and therefore will not be taxed.

Besides the exception pertaining to contributions to charitable organizations, another exception to the 10-year reversionary rule is made in Section 673, in the provision that this rule will not apply if the reversionary interest of the grantor is not to take effect until the death of the person or persons who are to receive the income under the trust.

In determining tax savings which can result from the use of a short-term trust, the applicability and the amount of gift tax must be considered. Property transferred to a *noncharitable* short-term trust is subject to a gift tax that is determined by the difference between the value of the property transferred and the value of the donor's retained interest. The donor's retained interest is the present value of what will be returned to him at the end of the trust.

There is no gift-tax obligation, however, on gifts to charitable trusts. Persons with large annual incomes, by creating a short-term trust, can obtain a much greater deduction with very little reduction in net income.

Under the 30 percent allowable deduction, a husband and wife with a gross income of $500,000 a year could contribute $150,000 to charity. Assuming other standard deductions of $2,200, their federal income tax would be $266,660, leaving a balance of net income of $83,060.

However, if this couple established a two-year short-term trust, they could contribute $250,000 to a qualified charity, and, after paying a federal income tax of approximately $177,182, they would have $72,818 remaining as net income.

Thus, by a simple temporary conversion of passive income, they could increase their contribution from $150,000 to $250,000 at a net loss of income to them of $10,242.

The charts on the opposite page indicate the great advantages of charitable short-term trusts for different income levels.

HOSPITALS SHOULD INFORM SUPPORTERS

Every charity owes a duty to itself, and to the individuals more than usually devoted to it, to make known to them the tax advantages inherent in the short-term trust of which the charity is the beneficiary.

Every taxpayer whose income reaches the 50 percent rung on the income-tax ladder should investigate carefully the tax savings applicable to his particular situation in the use of the short-term trust device.

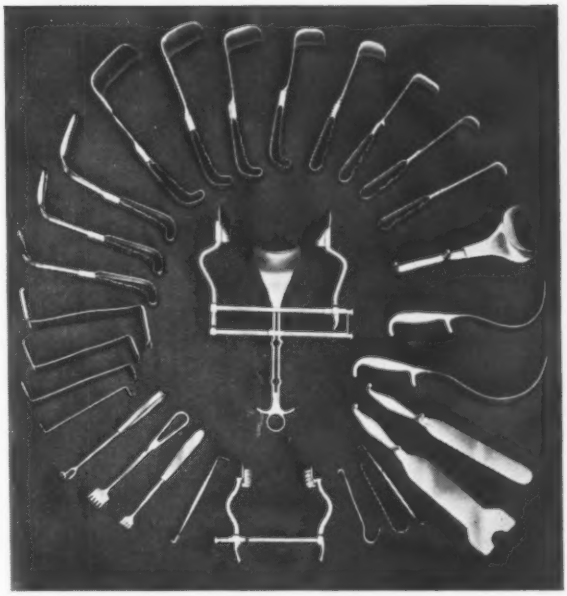
The successful use of this device is, of course, dependent upon care in the creation of the trust and cautious avoidance of the pitfalls contained in the complexities of the 1954 code and the regulations thereunder. Naturally, this is a job for an expert. But all hospitals should be aware of the possibilities for increased contributions through the use of the short-term trust.

Analysis has indicated that this device may well lead to steady contributions. Persons who establish such trusts often renew them when the initial period is up. Also the suggestion may be made that the gift be included as a bequest to the hospital in the donor's will.

Reprints of this article will be available for hospitals which want to purchase them to send to prospective donors.

COMING NEXT MONTH . . .

Planning a Capital-Fund Campaign for Your Hospital



STAINLESS STEEL

RETRACTORS

A complete assortment for all operating procedures, in durable stainless steel throughout (except where sott metals are required).

Improved designs of preferred types reflecting the excellence of Dittmar-Penn metallurgy, workmanship and finish for functional perfection in the surgeon's hands.

Ask your surgical supply dealer to show you the Dittmar-Penn Instrument Set Displays.

The complete **Dittmar-Penn Catalog** should be in every Hospital. Request your copy.

MEASURABLE QUALITY IN SURGICAL INSTRUMENTS . . .

Dittmar·penn

DITTMAR and PENN CORPORATION . 611 E. 19th ST., PHILADELPHIA 30, PA.

MANUFACTURERS AND WHOLESALERS

Revised Code of Ethics Released by AHA, ACHA

A revised code of ethics for hospitals and hospital administrators has been released by the American Hospital Association and the American College of Hospital Administrators. It supplants a code produced and adopted by these two organizations in 1939.

Prepared by a joint committee representing both groups, the revision consists of a 10-point statement on hospital ethics and a 10-point statement of principles of conduct for administrators.

A. P. Merrill, M.D., superintendent, St. Barnabas Hospital for Chronic Diseases, New York City, and a fellow of the ACHA, headed the joint committee which prepared the code.

The 10-point statement on hospital ethics is as follows:

1. Recognizing that the care of the sick is their first responsibility and a sacred trust, hospitals must at all times strive to provide the best possible care and treatment to all in need of hospitalization.

2. Hospitals, cognizant of their unique role of safeguarding the nation's health, should seek through compassionate and scientific care and health education to extend life, alleviate suffering, and improve the general health of the communities they serve.

3. Hospitals should maintain and promote harmonious relationships within the organization to insure the proper environment for the considerate and successful care and treatment of patients.

4. Hospitals should appreciate and respect individual religious practices and customs of the patient.

5. Hospitals, to the extent possible, should conduct educational projects, stimulate research, and encourage preventive health practices in the community.

6. Hospitals should cooperate with other hospitals, health and welfare agencies, governmental and private, and other recognized organizations interested in promoting the health of the nation.

7. Hospitals in reporting their work to the public should give a factual and objective interpretation of accomplishments and objectives without disparaging the work of other hospitals or related organizations.

8. Hospitals should actively support and encourage every effective method which will ease the financial burdens of illness.

9. Hospitals should be fair, honest, and impartial in all their business relationships.

10. Hospitals should be progressive in policies, personnel practices, and efforts to maintain up-to-date equipment, methods, and standards of performance.

Maine Collegiate Nursing School Re-Established

Re-establishment of a collegiate program of nursing education in cooperation with the Eastern Maine General Hospital, Bangor, has been announced by University of Maine president Arthur A. Hauck.

The new program was made possible through a gift from Rep. Frances Payne Bolton (R., Ohio) of $93,000 covering the first five years of the course.

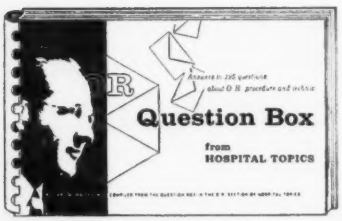
"The new collegiate school of nursing at the University of Maine will be the only one in the state and therefore will make a vital contribution to the training of nurse educators and administrators for Maine's hospitals and nursing schools," Mrs. Bolton said.

The first students will be admitted in the fall of 1958.

2 Books

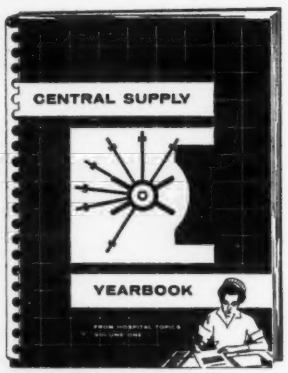
Published by HOSPITAL TOPICS

Order your copies today



OR QUESTION BOX
by Carl W. Walter, M.D.
1.00

Authoritative answers to 195 questions most frequently asked on operating room procedure and technic, compiled from the author's regular column in HOSPITAL TOPICS. This book will be a valuable reference aid to operating room supervisors and staff, directors of nurses, medical staff members, central supply supervisors, and administrators who want to keep informed on good operating room practices.



CENTRAL SUPPLY YEARBOOK vol. 1
1.50

HOSPITAL TOPICS was the first hospital publication to recognize the importance of the central supply department by establishing a special section for its personnel. From those articles the editors have carefully selected the ones which appear in this yearbook. They deal with every major CSR problem, whether it's methods of sterilization, inservice training, or work simplification. Among the authors: Margaret K. Schafer, R.N., Frederick Markus and Jean Christie, R.N., Velma Chandler, Ph.D., Betsey Carroll, R.N.

Hospital Topics, 30 W. Washington St., Chicago 2, Illinois

Please send me _____ copies of the Central Supply Yearbook at $1.50 each.
_____ copies of the Question Box at $1.00 each.
☐ Check is enclosed ☐ Bill me

Name_____

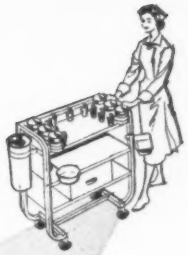
Address_____

City_____

State_____

HT-1057

Since 1860



KOENIG DRESSING AND SUPPLY CARRIAGE

TAKE COMPLETE DRESSING SERVICE TO THE PATIENT'S BEDSIDE

LARGE CAPACITY • FEATHER-TOUCH MOBILITY

Now, everything you need for complete bedside dressing service . . . in a compact, full-capacity, noiseless mobile unit. Rolls at a touch on recessed wheels which give complete foot clearance and protection against knocking casters out of line by bumping. It's lightweight, durable, easily cleaned and non-corrosive, because it is constructed of strong, square-tube aluminum with stainless steel working surfaces. This finest of mobile dressing carriages may be obtained complete with dressing jars, medication bottles.

The Koenig Dressing and Supply Carriage is part of outstanding Aloe Alumiline . . . equipment designed in close cooperation with experienced hospital personnel to meet the exact needs of modern hospitals. In surgery, nursery, delivery room, nurses' stations and general nursing service, Alumiline has proved itself in hundreds of hospitals across the nation.

GET THE COMPLETE ALUMILINE STORY
Mail coupon now for brochure that illustrates and describes the Koenig Dressing and Supply Carriage and other Alumiline Hospital Equipment.

a. s. aloe company
World's Foremost Hospital Supplier

14 FULLY-STOCKED DIVISIONS COAST-TO-COAST

A. S. ALOE COMPANY, 1831 Olive St., St. Louis 3, Mo.
Dept. 104

I would like to receive complete information on:

☐ Koenig Dressing and Supply Carriage;
☐ Alumiline Brochure.

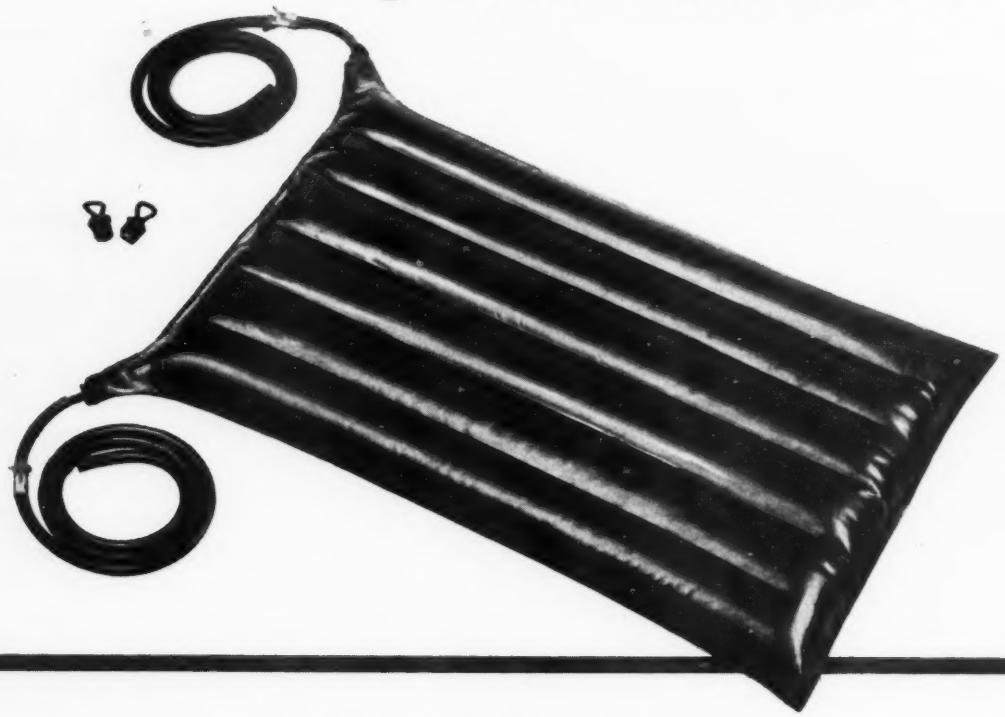
Name_____ Title_____

Hospital_____

Address_____

City_____ Zone____ State_____

improved
temperature control in
*pediatric anesthesia**



The McQuiston Water Mattress

NOW AVAILABLE IN CONDUCTIVE RUBBER

easily controls body temperatures of children

NEW—Inlet and outlet connectors are located at the same end of mattress. This provides more effective water circulation and efficient control. Assures faster temperature control during anesthesia as well as during the critical post-operative, recovery period.

The McQuiston Water Mattress is portable and can be used for the control of hyperpyrexia in the crib as well as in the operating room.

Surgeons report that a cold water mattress is more efficient than ice bags in the prevention of hyperpyrexia. Also, effective hypothermia during pediatric operative procedures can be easily produced and maintained, and restoration of bodily temperature is promptly effected.

Davol Conductive Rubber Products are color-fast, non-bleeding. Will not stain—can be sterilized just like other rubber products. Available at your Hospital Supply Dealer.

DAVOL® RUBBER COMPANY
PROVIDENCE 2, R. I.

**Body Temperatures during Anesthesia in Infants and Children: Bigler, John A., and McQuiston, William Otis, AMA Jl. June 9, 1951: 551-556 . . . Indications for Cooling in Pediatric Anesthesia: Terry, Richard N., New York State Journal of Medicine, Jan. 1, 1957:105-107*

Business Office Operations

Twelfth in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

Accumulation of Patient Charges

● Patient accounts generally are initiated in the requisition system or the chart system.

In the requisition system, pre-numbered triplicate requisitions are used for every operative procedure, dressing tray, cast room, and all drugs—in fact, any item used for the patient, with the exception of the daily service charge for room and board. Requisitions are prepared by the supervising nurse. Two copies are forwarded to the business office. The original is filed in alphabetical order by patient; the duplicate is filed in numerical order to maintain numerical sequence.

The following safeguards should be used: First, there should be a complete accounting of every requisition. This is done through the use of the duplicate copies, as these are filed in numerical order. It is obvious that any missing requisition will be instantly spotted. Second, there should be checking back and forth between the doctor's orders and the nurses' notes.

Charge tickets are generally not used for the daily room and care charges. Certain drugs and medical supplies may be placed on a nonchargeable list, and charge tickets are not prepared for these items issued from floor stocks. With these exceptions, and unless the hospital is using a comprehensive daily charge, all other services require issuance of charge tickets.

Charge tickets are usually initiated by the nursing service, and constitute a request for services to the patient by the diagnostic and ancillary service departments. The department renders the service requested, and may then price the charge ticket, or it may be priced by the business office. Packs of charge tickets are transmitted daily from the service departments to the business office. These packs require careful handling and should be subject to the normal cash controls, for they represent the day's income of the various departments.

Hospitals which already have addressograph equipment, or which are large enough to justify an addressograph installation, are usually urged to use the charge-plate system for identifying patient charge tickets. Under this system, an addressograph plate is prepared for each patient at the time of admission. This plate includes essential information, such as the patient's name, the name of his physician, his room and bed number, his admission or unit number, and a code indicating his financial classification. Charge-stamping machines must be purchased and installed on each nursing unit and at each cash-handling focal point in the service and ancillary units.

Normally, the plate will accompany the patient's chart from the admitting office through the medical record library to the nursing unit. It will be kept with the patient's record during his entire hospitalization, and will be returned to the cashier's office at the time of discharge.

Whenever drugs, surgical supplies, x-ray, laboratory, or other diagnostic services are required, a requisition form will be completed, and the patient's charge plate will be used to identify that requisition slip. Following this procedure will not only avoid numerous possibilities for errors, but will conserve the expensive time of the professional and clerical personnel.

A device called the Dupli-punch can supplement or, in a smaller hospital, substitute for the addressograph plate. With the Dupli-punch, a key card is used to notch essential information on each charge ticket, in much the same manner as the imprinting is done by the addressograph plate.

Analysis of charge tickets to determine the proportionate income from various types of accommodations and various nursing units is an integral part of the cost-accounting system. Charge tickets can be designed to contain data that can be analyzed in detail to provide the information required for cost analysis.

CHART SYSTEM

This method of accumulation of patients' charges derives its name from the fact that all pharmacy items, dressing trays, and the like are taken direct from the nurses' notes. The list is then cross-checked against the doctor's order sheet to make certain that all items have been picked up. This is a very simple method but does not have the control feature of the requisition method.

The patient's financial record is charged daily for all medications administered up through the preceding noon, for example. An identifying mark is placed on the chart, so that at a subsequent time anyone else will be able to tell to what point the chart has been charged.

This information should be accumulated daily. It is poor public relations to ask a patient to wait in the business office for a long period while his charges are being computed. Likewise, unless the charges are accumulated daily, the administrator has no way of knowing what his daily income is.

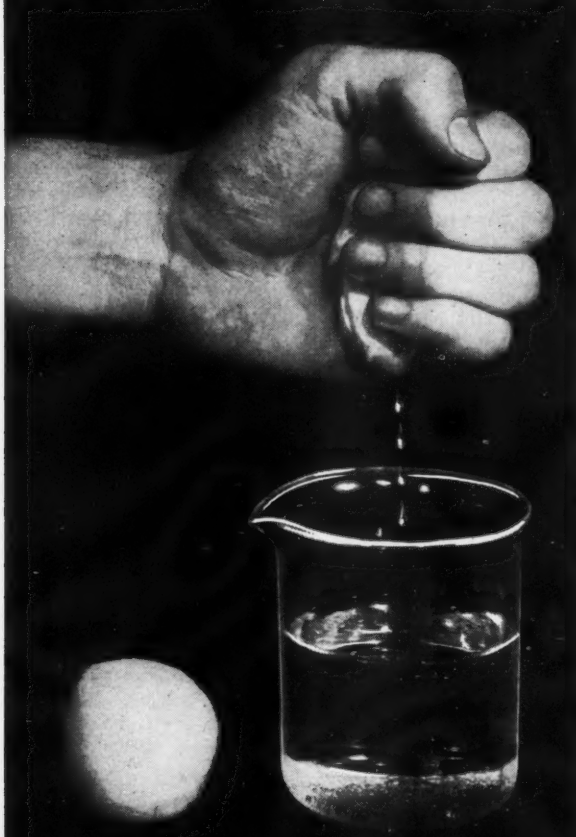
In every instance the entries made by the medicine or treatment nurse would be checked against the doctor's orders. It is always possible that for some reason the nurse who administered a medication or treatment has failed to make her entry on the chart. Particularly is this likely on the morning of discharge, when the doctor,

(Continued on next page)

*Administrator, La Mesa (Calif.) Community Hospital, and former chairman, Community Hospital Section, Assn. of Western Hospitals.

Dust Free! Lint Free!
Fuzz Free!
Combined with
Highest Absorbency

ACME
RAY-BALLS



The optimum of absorbency! Instantaneous! Sponge-like! Developed after exhaustive hospital tests. No annoying "wisps" or "strings".

AVAILABLE IN ALL SIZES

Write Today For FREE Samples
and money-saving prices of Acme's new RAY-BALLS

ACME COTTON PRODUCTS Co., Inc.
245 FIFTH AVENUE, NEW YORK 16, N. Y.
Manufacturers of a complete line of high quality surgical dressings

for example, may sign the patient out at 7 o'clock. The nurse administers an 8 o'clock medication, the chart has gone to the business office to be figured, and the charge for the 8 o'clock medication is overlooked.

SPECIAL ITEMS OF CHARGE

There are a number of special items that present particular problems in controlling charges:

Rented equipment, such as oxygen tents and orthopedic devices:

The most effective manner of controlling these items is to request that the lessor of the equipment furnish a duplicate invoice at the time delivery is made. The original copy of the invoice will go to the business office with the patient's name shown thereon. The duplicate copy with the patient's name will be filed with requisitions for the patient's other charges. This insures that the patient is charged for the equipment he has rented.

Oxygen:

This can be controlled best by attaching to each tank of unused oxygen two slips of paper. One slip of paper is filled out as soon as the tank is connected to the tent or catheter or whatever method is being used. Then, when the oxygen is discontinued, the amount of gas remaining in the tank is placed on the second slip, and that too is forwarded to the business office. This is a very effective method, particularly in an installation which is not using any of the new types of oxygen-measuring apparatus.

Outgoing or collect telephone calls:

Effective control actually requires installation of a 24-hour operator switchboard. Many community hospitals do not have such an elaborate set-up. The only safe method then, when the business office closes, is to lock or place a plug in the dialing mechanism of any telephone not under direct supervision of the nurse in charge. It has been found that many of the untraceable outside calls are made from remote stations.

Excess linen or guest trays:

This charge should originate with the housekeeping or the dietary department. If the policy of the hospital permits it and guests are fed in the room, the dietary department should immediately upon request prepare a slip for the account of the patient, indicating that an extra tray was prepared and taken to room so and so. If this is done, there will be no loss of revenue from this item.

The hospital aide or undergraduate can assist in the control of excess linen if she will report to the nurse in charge that she has made an extra change of linen for a particular patient. Most hospitals allow for two changes per day without extra charge. Others allow for one change in the morning. However, a patient who is incontinent and requires a number of changes per day can rapidly become an expensive item which does not show up on any cost sheet.

PERPETUAL INVENTORY AND CONTROL OF DRUGS

A perpetual inventory should be maintained by even the smallest hospital. Its value in controlling medications is in the fact that an item such as aureomycin may be checked out to the medicine room, and then the use of that drug can be tallied from the doctor's order sheet and the entries that the medicine nurse makes on the nurses' notes. It is obvious that if 100 aureomycin tablets are checked out, 100 tablets should turn up as charges to patients.

Ready Reference of Hospital Facts

For Planning and Operation

Part XX

By Louis Block, Dr. P.H.

Federal Hospitals in the United States*

• From 1946 to 1954 the activities of the federal hospitals in the United States have shown some marked changes, especially in the number of facilities available, their utilization, finances and personnel. These hospitals now account for 6.2 percent of all hospitals; 12.0 percent of all beds; 11.9 percent of the average days of care provided; 7.0 percent of all admissions, and 17.7 percent of all expenses.

Facilities:

1. The number of hospitals has increased by 26 (from 404 to 430)— an increase of 6.4 percent.

2. The number of beds has decreased by 46,731 (from 235,964 to 189,233)—a decrease of 19.8 percent.

Utilization:

1. The average daily census has decreased by 6,837 (from 166,356 to 159,519)—a decrease of 4.1 percent.

2. The percentage of occupancy has increased from 70.5 percent to 84.3 percent.

3. The number of admissions has decreased by 172,819 (from 1,593,335 to 1,420,516)—a decrease of 10.9 percent.

Finances:

1. Total assets have increased $993,121,000 (from $811,630,000 to $1,804,751)—an increase of 122.4 percent.

2. Total expenses have increased $553,793,000 (from $372,960,000 to $926,753,000)—an increase of 148.5 percent.

3. Total expenses per patient day have increased $9.78 (from $6.14 to $15.92)—an increase of 159.3 percent.

4. Payroll expense has increased $455,483,000 (from $246,795,000 to $702,278,000)—an increase of 184.5 percent.

5. Payroll expense per patient day has increased $8 (from $4.06 to $12.06)—an increase of 197.0 percent.

Personnel:

1. The number of full-time personnel has increased by 32,607 (from 161,925 to 194,532)—an increase of 20.1 percent.

2. The number of full-time personnel per 100 patients has increased by 25 (from 97 to 122)—an increase of 25.8 percent.

Following are some pertinent facts concerning the average federal general hospital in the United States.

The Average Federal General Hospital in the United States*

Facilities:

1. Number of beds	317

Utilization:

1. Number of annual adult admissions	3,726
2. Average daily adult census	249
3. Percentage occupancy	78.5
4. Average length of adult stay in days	24.4

Financial:

1. Total assets	$3,891,182
2. Plant assets	$3,823,300
3. Percent plant assets of total assets	98.3
4. Total annual expenses	$1,832,386
5. Total expenses per patient day	$20.17
6. Annual payroll	$1,385,331
7. Payroll per patient day	$15.25
8. Percent payroll of total expenses	75.6

Services:

1. Percent of hospitals offering:	
a. Blood bank	55.5
b. Cancer clinic	31.3
c. Central suppy room	81.6
d. Children's education program	10.3
e. Clinical laboratory	96.8
f. Dental department	94.8
g. Electrocardiograph	93.5
h. Electroencephalograph	35.2
i. Hospital auxiliary	39.4
j. Library, medical	92.3
k. Library patient	78.1
l. Medical record department	96.1
m. Mental hygiene clinic	15.8
n. Metabolism apparatus	91.0
o. Occupational therapy department	49.7
p. Outpatient department	81.0
q. Pharmacy	89.7
r. Physical therapy department	81.9
s. Postoperative recovery room	59.4
t. Premature nursery	32.6
u. Radioactive isotopes	14.8
v. Rehabilitation department	40.3
w. Social service department	57.4
x. X-ray therapy	97.1
y. X-ray, routine chest, on admission	79.7
z. X-ray therapy service	34.8

Personnel:

1. Number of full-time personnel	390

(Continued on next page)

*Based on information in American Hospital Association's Administrators' Guide Issues (1951-1955).

2. Number of full-time personnel per 100 patients	157
3. **Nursing personnel:**	
a. Total graduate nursing personnel	54
(1) Administrative graduate nursing personnel	2
(2) Full-time instructors	1
(3) Supervisors and assistants	4
(4) Head nurses and assistants	10
(5) General-duty nurses, full time	36
(6) General-duty nurses, part-time	1
(7) Nurses not classified	2
b. Private-duty nurses	0
c. Practical nurses	13
d. Attendants	56
e. Nurses' aides	55
f. Ward maids	30
g. Orderlies	10
4. **Medical technologists:**	
a. Registered, full-time	2
b. Registered, part-time	0
c. Other full-time	8
d. Other part-time	0
5. **X-ray technicians:**	
a. Registered, full-time	1
b. Registered, part-time	0
c. Other full-time	4
d. Other part-time	0
6. **Occupational therapists:**	
a. Registered, full-time	3
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
7. **Physical therapists:**	
a. Registered, full-time	2
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
8. **Dietitians:**	
a. Full-time	4
b. Part-time	0
9. **Medical social workers:**	
a. Full-time	4
b. Part-time	0
10. **Pharmacists:**	
a. Full-time	3
b. Part-time	0
11. **Medical record librarians:**	
a. Registered, full-time	1
b. Registered, part-time	0
c. Other full-time	1
d. Other part-time	0
12. **Other medical record personnel:**	
a. Full-time	7
b. Part-time	0

DEPARTMENTAL

1. Percent hospitals accredited by the Joint Commission on Accreditation of Hospitals	62.5

Administrator:

1. Percent hospitals having administrative staff member on duty at night	71.0
2. Percent hospitals delegating administrative responsibility to night supervising nurse	21.5

Laboratory:

1. Percent hospitals having unrinalysis on all admissions	87.7
2. Percent hospitals having blood count on all admissions	76.5
3. Percent hospitals having serological examinations for syphilis on all adult admissions	78.3
4. Percent hospitals having electrocardiograms on all admissions over 45 years of age	18.0
5. Percent hospitals having Rh grouping on all pregnancy cases	42.6
6. Percent hospitals having preoperative blood grouping on all surgical cases	50.2
7. Percent hospitals having preoperative coagulation on all tonsillectomies	67.5
8. Percent hospitals having postoperative urinalysis on all surgical cases	51.6
9. Percent hospitals having no tests without doctors' orders	10.1

Outpatient Department:

1. Number of annual clinic visits	25265
2. Number of annual private outpatient visits	0
3. Number of annual emergency visits	5462

Medical Records:

1. Number of annual deaths	94
2. Percent deaths of admissions	2.0
3. Number of annual autopsies	64
4. Percent autopsies of deaths	67.8
5. Number of annual deaths released to legal authorities	9
6. Percent hospitals using Standard Nomenclature of Diseases and Operations	84.8

Are You Purchasing the Best SURGICAL NEEDLES Available?

INSIST ON THE GENUINE

Leading Hospitals **insist on FENGEL SUPERIOR SURGICAL NEEDLES because:**

FENGEL NEEDLES are made in REDDITCH, ENGLAND the *Needle Capital of the World.*

FENGEL NEEDLES are far *Superior* because they are the result of *generations* of *experience* and *"know-how."*

FENGEL NEEDLES are made *rustproof* by a *secret non-corrosive process.*

FENGEL NEEDLES are made in the *largest range* of *styles* and *sizes*, including SPRING EYE NEEDLES.

FENGEL NEEDLES are always stocked in such great quantities that *every order* is *shipped complete the day it is received.*

THE FENGEL CORP.

239 Fourth Ave. New York 3, N .Y.

West Coast Office:

1100 S. Beverly Drive Los Angeles 35, Calif.

Admitting:

1. Percent hospitals routinely treating the following types of patients:
   - a. Alcoholics 26.7
   - b. Cancer 65.0
   - c. Cardiac 82.6
   - d. Dermatologic 81.0
   - e. Drug addiction 14.8
   - f. Epileptic 58.8
   - g. Gynecologic 71.4
   - h. Isolation (contagion) 67.5
   - i. Leprosy 3.9
   - j. Medical 99.4
   - k. Mentally deficient 17.0
   - l. Neurologic 62.4
   - m. Obstetric 52.4
   - n. Ophthalmic 75.2
   - o. Orthopedic 85.2
   - p. Otorhinolaryngologic 72.7
   - p. Poliomyelitis 38.3
   - r. Psychiatric 48.6
   - s. Surgical 96.5
   - t. Tuberculosis 44.7
   - u. Urologic 79.4
   - v. Venereal disease 73.6
   - w. Acutely ill 99.0
   - x. Chronically ill 74.5
   - y. Students exclusively 0
   - z. Convalescent and rest 11.6
   - aa. Geriatric 27.7
   - bb. Industrial 23.9
   - cc. Pediatric 49.7
   - dd. Prisoners exclusively 6.5
9. Percent general hospitals admitting psychiatric patients 46.4
10. Of those general hospitals admitting psychiatric patients—
    - a. Percent in separate buildings 11.0
    - b. Percent in separate departments in same building 70.1
    - c. Percent in no separate facility 16.5

Accounting:

1. Percent hospitals operating under formal budgets 80.8
2. Percent hospitals using AHA chart of accounts 2.2

Public Relations:

1. Percent hospitals using patient opinion poll 20.4
2. Percent hospitals using personnel opinion poll 11.2
3. Percent hospitals using medical staff opinion poll 5.8
4. Percent hospital using community opinion poll 0.3
5. Percent hospitals using none of these 73.1

Laundry:

1. Percent hospitals operating own laundry and processing all soiled linen 62.6
   - a. Number of pounds processed per week 24,580
   - b. Number of pounds processed per patient day 8.3
2. Percent hospitals operating own laundry and processing only a part of soiled linen 1.1
   - a. Number of pounds per week 5,452
   - b. Number of pounds per patient day 8.4
3. Percent of hospitals not operating own laundry 36.3
   - a. Number of pounds processed per week 6,996
   - b. Number of pounds processed per patient day 8.0

Auxiliaries:

1. Percent hospitals having organized auxiliaries 47.1

Safety:

1. Percent hospitals having own written plan for mobilization of employees and medical staff 86.9
2. Percent hospitals whose written plan is integrated in master community plan 60.1
3. Percent hospitals represented on a community disaster planning committee 61.7

Religious:

1. Percent hospitals with a chapel 58.0
2. Percent hospitals with a meditation room for prayer 41.9
3. Percent hospitals with organized visiting clergy staff 51.0
4. Percent hospitals having chaplains available 93.4
5. Percent hospitals with full-time chaplains 51.8
6. Percent hospitals with part-time chaplains 20.4
7. Percent hospitals with chaplain on call only 18.4

YOURS....

KAYE Perma-Black

Ask Your Dealer for Our Low Price Hospital Bulk Package Offer

*Perma-Black Exclusive with KAYE

Complete Line of Quality Thermometers Meeting All State and Federal Regulations

"Your Assurance of the Finest"

KAYE THERMOMETER CORP.
230 3rd ST. BKLYN.15, N. Y.

HAVE YOU EVER FIGURED HOW MUCH IT COSTS

To cut a 2 oz. spool—700 feet—of No. 32 wire into suture lengths, trim, bundle and tube?

BY COMPARISON

Steri-Spools®

Used in Halliday Wire Cutting Dispensers

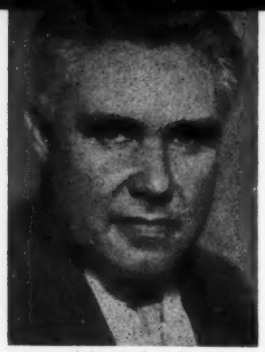
COST YOU LESS THAN NOTHING

If your dealer cannot supply, write to

THOMAS W. HALLIDAY

Manufacturer

911 N. WESTMOUNT DRIVE LOS ANGELES 46, CALIF.



John G. Steinle

Consultant's Corner

By John G. Steinle

Q. What should the bed distribution be, by clinical services, in a 600-bed university hospital?

A. It is impossible to categorically answer this question. The hospital should first carefully define its function. The responsibility which it shall have to provide patient care, separate from that necessary to provide teaching experience, should be determined. If its function is exclusively to provide teaching experience, it need not be concerned with the needs of the community. If, as in the case of most teaching hospitals, it also has a primary community responsibility, it should consider the total needs of the community, and the existing and planned beds in other hospitals for meeting these needs.

In planning beds for a teaching program, the clinical schedules for each department should be determined. The relation of students, the number assigned at one time or in one block to each service, and the number of internships and residencies to be provided, should be considered in the total number of beds necessary for the teaching program. Other beds that are to be used for teaching purposes in the community must be taken into account. Estimates for the number of beds necessary for an effective teaching program range from six to 11 per junior and senior student.

Analysis of 20 medical schools indicates the following average distribution of beds.

- Medicine (including neurology) 28 percent
- Surgery 37 percent
- Pediatrics 9 percent
- Psychiatry (acute only) 10 percent
- Obstetrics and gynecology 16 percent

The above distribution varies tremendously between medical schools.

Q. Should emergency room records be maintained with the inpatient files, outpatient files, or separately?

A. There is only one effective method of maintaining medical records—the unit system. All records should be maintained in one central record room. If records are maintained separately for outpatients and for inpatients, it does not make too much difference where emergencies are kept since there will not be a satisfactory system in any event. The usual procedure for those hospitals with separate systems, we are told, is if the patient is admitted, the record becomes an inpatient record; if the patient is not admitted, the record is kept with outpatient records. Emergency medical records should not be kept separately.

Q. In the July issue of HOSPITAL TOPICS you gave time standards for laboratory procedures. Did these standards include protein-bound iodines, transaminase, electrophoresis, and micro procedures?

A. They did on the assumption that these procedures were included in the total annual work load. The time standards would not apply to a single bacteriologist, chemist or technician, a large part of whose work time is spent on these procedures. The criteria would not apply to a children's hospital that has a large number (more than 10 percent of the total procedures) of micro procedures, both with blood or with potassiums, sodiums and the like.

Q. Will the presence of a Ph.D. chemist and bacteriologist improve the production in the laboratory?

A. No. They will probably improve performance qualitatively but not quantitatively.

It has been interesting to note that the advent of a biochemist is usually marked by an immediate increase in the number of complex procedures requested by the medical staff. We have been told by staff members that this is not due to any capriciousness. The procedures were always desirable, but had not been requested because of lack of confidence in the results.

Q. What is considered an adequate medical library for a hospital under 100 beds?

A. I believe that the best basic library holding list that has been developed for your purpose is the one in the publication, "The Medical Library . . . a Vital Force." This can be obtained from The Catholic Hospital Association, 1438 South Grand Blvd., St. Louis 4, Mo.

Q. What are the requirements for nurses' meetings?

A. The director, supervisors, and head nurses should meet at least once a month. There should be a regular published agenda. At least one hour of each meeting should be devoted to the following subjects:

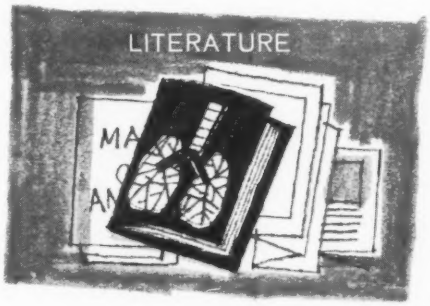
New technics of nursing
General administrative problems
Coordination of activities with other departments
Problems of integration with the educational program (if there is a school of nursing)
Methods improvement
Training programs
Recruitment.

Many hospitals have found that regular meetings of the entire nursing staff are invaluable for developing good morale. These meetings should include an interesting and stimulating speaker, and two complete identical sessions must be held, so that all nurses can attend.

A separate "nurses' association" is also recommended. This association should plan education and recreational events. Representatives of the association should meet with management to consider salary, vacation, sick leave, fringe benefits, and other personnel policies.

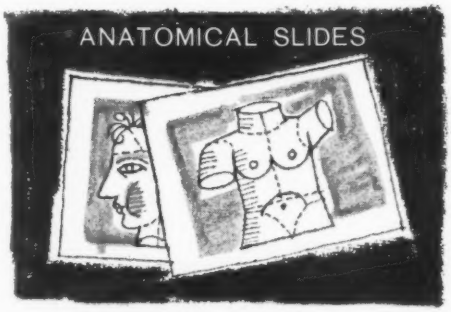
THESE CIBA TRAINING AIDS CAN HELP YOU

To obtain any of the numerous informational and teaching aids produced by CIBA, please write to the particular departments noted below.

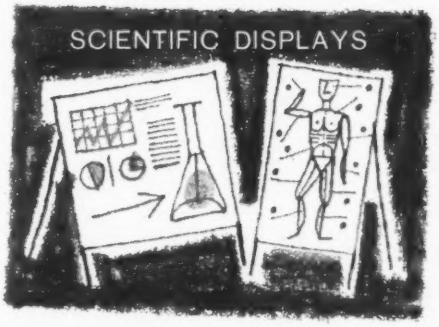


Booklets, brochures and reprints concerning CIBA products will be sent free of charge on request to the Medical Service Department, CIBA, Summit, New Jersey. In addition, three volumes of particular interest from THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS by Frank H. Netter, M.D.—Vol. 1, *Nervous System** ($7); Vol. 2, *Reproductive System* ($13); and Vol. 3, Part III, *Liver, Biliary Tract and Pancreas* ($10.50)—may be obtained by sending check or money order to Publication Department, CIBA, Summit, New Jersey.

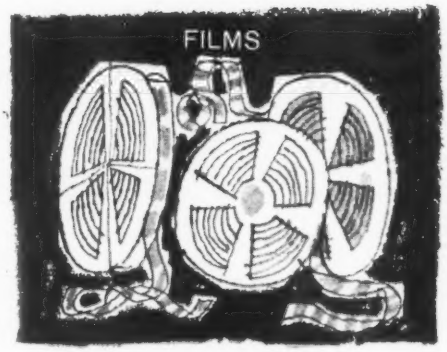
*3rd printing, including Supplement on the Hypothalamus.



An extensive library of colored anatomical slides (art work by Frank H. Netter, M.D.) is available for loan or purchase. A complete list of the slides may be obtained by writing the Publication Department, CIBA, Summit, New Jersey.



The latest scientific information on products manufactured by CIBA is presented in exhibit form for the benefit of staff doctors—without interference with hospital routine. You may write to the Hospital Sales Department, CIBA, Summit, New Jersey, requesting a display on a convenient date.



A library of 16 mm. medical films, some in color, with sound may be borrowed to be used as teaching aids for nurses, residents and internes, or as part of refresher courses and staff meetings. If you wish, projection equipment and a qualified operator will be provided without charge. A list of film titles is available from the Hospital Sales Department, CIBA, Summit, New Jersey.

Booking Arrangements for Films: Please make requests at least 3 weeks prior to showing date to the nearest office of distributing agents—

IDEAL PICTURES CORPORATION

East—233-239 West 42nd Street, New York 36, New York. Tel.: LAckawanna 4-0916.
Central—58 East South Water Street, Chicago 1, Illinois. Tel.: FInancial 6-5245.
South—18 South Third Street, Memphis 3, Tennessee. Tel.: 37-4313.
West—2161 Shattuck Avenue, Room 29, Berkeley 4, California. Tel.: THornwall 3-6464.
Hawaii—1370 South Beretania Street, Honolulu, T. H. Tel.: 65336.

CIBA
SUMMIT, N. J.

2/241918

Personally Speaking

Paul M. Ahlstedt—has been appointed administrator, new Methodist-Evangelical Hospital, Louisville, Ky., scheduled for construction this winter. He was former administrator, Wichita General Hospital, Wichita Falls, Tex.

Carden M. Astin—has been appointed administrator, Lawrence County Hospital, Lawrenceville, Tenn.

Russell L. Austin—has been appointed chief pharmacist, Providence Hospital, Portland, Ore.

Elsa Baumgart—has resigned as chief therapist, physical therapy department, Mount Zion Hospital, San Francisco. No successor has been named.

Charles Becker—has become administrator, Burnham City Hospital, Champaign, Ill., succeeding **William B. Robinson**, who has become administrator, Ryburn Memorial Hospital, Ottawa, Ill.

Patrick Blewett—has become business manager, Providence Hospital, Portland, Ore. He was formerly hospital consultant, British Columbia Hospital Insurance Service, Victoria, B.C.

Joseph J. Braun—has been appointed regional director, National Jewish Hospital at Denver, Colo.

Elizabeth Bristol—has been appointed nursing director, Porter Hospital, Middlebury, Vt., assuming duties formerly handled by **Glenna Corey**, who continues as superintendent.

Marjorie E. Burr—has resigned as chief dietitian, Manchester (Conn.) Memorial Hospital, to continue her education.

Anne Chapman—has resigned as head, nursing education, Memorial Hospital Association, UMW hospitals, Williamson, W. Va., to enter graduate training.

Mrs. Irene Ciminera—has succeeded **Roy Mitchell** as administrator, Tri-County Hospital, Deer Park, Wash. She is a former administrator, Garfield Memorial Hospital, Pomeroy.

Mrs. Marjorie Coleman—has been appointed director, nursing service, Anniston (Ala.) Memorial Hospital.

Evelyn Conners, R.N.—has become personnel director, St. Vincent Hospital, Portland, Ore., succeeding **Ben Hecht**, who has become business manager.

Mrs. Margaret D. Connors—has been appointed assistant superintendent, Rockville (Conn.) City Hospital, where she has been evening supervisor.

George W. Dana, M.D.—has been appointed director, North Shore Hospital, Manhasset, L.I., N.Y., succeeding **John M. Danielson**, now administrator, Evanston (Ill.) Hospital. Dr. Dana was formerly medical staff director, New England Center Hospital, Boston.

Ervin Daugherty—has been named administrator, Henderson (Tex.) Memorial Hospital.

June DeBaise—has been named public relations director, Meriden (Conn.) Hospital, succeeding **Mrs. Marion Stevenson.**

Lawrence E. Dickovick—has been named assistant general manager, Memorial Center for Cancer and Allied Diseases, New York City. He was formerly associate administrator, Community Hospital, Glen Cove, N.Y.

Carolyn Dobson—has been appointed supervisor, nursing service, Anniston (Ala.) Memorial Hospital.

Donna M. Donald—has been appointed administrator, Albany (Calif.) Hospital, where she was formerly a research and teaching associate in hospital administration.

Sol Dorinson, M.D.—has become head, department of physical medicine, Mount Zion Hospital, San Francisco.

Thomas E. Dredge, M.D.—has become manager, VA Hospital, Tomah, Wis., succeeding **Benjamin F. Jackson, M.D.** Dr. Dredge was formerly director, professional services, VA Hospital, St. Cloud, Minn.

Ferrell B. Driskell—has been appointed administrator, Rhea County Memorial Hospital, Dayton, Tenn., a new institution.

David S. Egan—assistant administrator, Bridgeport (Conn.) Hospital, has retired. No successor has been named.

Agnete Fenger—has been appointed to the newly-created position of associate director of nursing in charge of outpatient services, The Children's Hospital, Columbus, O. She was formerly director of nursing, St. Christopher's Hospital for Children, Philadelphia.

Carl Flath—has been appointed administrator, Pontiac (Mich.) General Hospital.

Ernest C. Gray, Jr.—has become administrator, Lake Forest (Ill.) Hospital, succeeding **Liala I. Johanson**, who has resigned. Mr. Gray was formerly assistant to the director, University Hospitals of Cleveland, O.

Charlie Grewe—has become administrator, Pemiscot County Memorial Hospital, Hayti, Mo., succeeding **Mrs. Opal Parks**, who has resigned.

Marion A. Hadfield, R.N.—has become nursing service director, Canonsburg (Pa.) General Hospital, succeeding **Ruth E. Benfield.**

Mrs. Dorothy Hardin—has become O.B. supervisor, Anniston (Ala.) Memorial Hospital, a newly-created position.

William A. Harvey, M.D.—formerly educational director, The Institute, Pennsylvania Hospital, Philadelphia, has been appointed director, outpatient department, The Institute.

Noble O. Hoover—has been appointed administrator, Mason District Hospital, Havana, Ill., now being built. He was formerly administrator, Mennonite Hospital, Bloomington, Ill.

Roy C. House—has been named administrator, The Wesley Hospital and Nurse Training School, Wichita, Kans., succeeding **Armour H. Evans.**

Leon A. Jaris—has become administrator, Motion Picture Hospital, Woodland Hills, Calif. He was formerly administrator, Albany (Calif.) Hospital.

Albert W. Jones—has been named administrator, Bethesda Hospital, Zanesville, O. He was formerly assistant administrator, Ball Memorial Hospital, Muncie, Ind.

Harold L. Jones—has been elected administrator, Missouri Delta Community Hospital, Sikeston, Mo., succeeding **Robert J. Genins.** Mr. Genins has become associated with the General Board of Lay Activities, Methodist Church, Chicago.

Mrs. Esther Kalb—has been named director, nursing service, Boone County Hospital, Columbia, Mo., succeeding **Elaine Schack**, who will continue as staff member.

Orville C. King, M.D.—has been appointed acting director, division of surgery, department for sick and injured, Pennsylvania Hospital, Philadelphia.

William B. Kramer—has become executive secretary, San Francisco Hospital Conference. He was formerly assistant director, Mount Zion Hospital, San Francisco.

Arthur M. Lawrence—has been named director, public relations, Hospital Service Association of Western Pennsylvania (Blue Cross).

Elsa C. Lusebrink, R.N.—has been named assistant administrator, Danbury (Conn.) Hospital. She will continue as director, department of nursing service and education.

Mrs. Norrine Major—has been appointed director of nursing and principal, School of Nursing, Western Pennsylvania Hospital, Pittsburgh.

Gerald J. Malloy—has been named executive director, Greater St. Louis Hospital Council. He is assistant administrator, St. John's Hospital, St. Louis, Mo.

Alfred Muller, Jr.—is now assistant administrator, General Hospital of Everett, Wash. He was former administrative assistant, St. Francis Memorial Hospital, San Francisco.

John D. Mulliken, Jr.—was appointed administrator, Uvalde (Tex.) Memorial Hospital. He was formerly assistant administrator, Valley Baptist Hospital, Harlingen, Tex.

Mrs. Helen Myers, R.R.L.—has been appointed medical record librarian, Salem (Ore.) Memorial Hospital. She was formerly head librarian, Tacoma (Wash.) General Hospital.

Ildaura Murillo—has become supervisor, psychiatric nursing staff, Elmhurst General Hospital, New York City, scheduled to open soon.

Albert B. Osborne—has been named administrator, Centreville Township Hospital, near East St. Louis, Ill., to be opened March 1.

John C. Panzer—has been named manager, new Battle Creek (Ia.) Hospital. He was formerly manager, Bassett (Nebr.) Hospital.

Philip R. Partington, M.D.—has been appointed assistant medical director, Hartford (Conn.) Hospital, where he has been director, outpatient department.

Peter Pierdinock—has become assistant administrator, Bridgeport (Conn.) Hospital.

Nettie R. Price, R.N.—has been appointed director, department of nursing, Jewish Hospital of Brooklyn, (N.Y.). She was formerly assistant director, nursing service.

Victory Quillen—has retired as director of nurses, Paris (Ill.) Hospital, after 35 years. **Mrs. Treva Finney, R.N.**, formerly assistant director, will succeed her.

Lester S. Reavley, M.D.—is new president, Illinois State Medical Society.

Arthur C. Reese—has been appointed comptroller, Ohio Valley General Hospital, Wheeling, W. Va.

Mildred A. Richardson—has retired as director, nursing service and education, Bridgeport (Conn.) Hospital.

William A. Roecker—has resigned as managing director, Children's Hospital School, Eugene, Ore.

Mrs. Muriel M. Russell—has become assistant administrator, New Bern (N.C.) Hospital. She was formerly administrator, New Milford (Conn.) Hospital.

Robert Schinderle—has become personnel director, Mercy Hospital, Chicago, a new post. He was formerly credit manager.

Fred W. Schmid—has resigned as administrator, Bradford (Pa.) Hospital.

David V. Shaw—has become administrator, Dukes-Miami County Memorial Hospital, Peru, Ind. He was formerly administrator, New Milford (Conn.) Hospital.

Sister M. Eileen, O.S.F.—has been appointed administrator, St. Francis Hospital, Grand Island, Neb., and will continue as superior. She was formerly at St. Francis Convalescent Hospital, Colorado Springs, Colo.

Sister Mary Esther—has been appointed administrator, Our Lady of Lourdes Hospital, Pasco, Wash., succeeding **Sister Mary Eileen.** She was formerly administrator, St. Joseph's Hospital, Lewiston, Ida.

Sister Mary Getulia—has been appointed superior, St. Mary of Nazareth Hospital, Chicago, where she was formerly chief pharmacist. She succeeds **Mother Mary Flavilla,** who will become a teacher.

Sister Mary Grace, R.S.M.—was appointed administrator, Mercy Hospital, Cadillac, Mich., succeeding **Sister Maureen.**

Sister Mary Ida, R.S.M.—formerly business office manager, Mercy Hospital, Muskegon, Mich., has been appointed administrator, Mercy Hospital, Manistee, Mich.

Sister Mary Magdalene, R.S.M.—has been named assistant administrator and business manager, St. John's Hospital, St. Louis, Mo.

(Continued on page 55)

CLASSIFIED

SHAY MEDICAL AGENCY

Blanche L. Shay, Director
Pittsfield Bldg., 55 E. Washington St.
Chicago 2, Illinois

POSITIONS OPEN

DIETITIANS: (a) Chief. California. 300-bed hospital. 55 employees in dept. $6,000. (b) Chief. West. 100-bed hospital in town of 35,000. $6,000. (c) Therapeutic. Middle West. 185-bed hospital, near Chicago. $4,800. (d) Therapeutic. Middle West. Special diets and patient instruction. 150-bed hospital. $5,400. (e) Chief. South. A.D.A. required. 200-bed hospital in town of 35,000. $5,000 up. (f) Administrative. East. 270-bed teaching hospital. Supervise entire food service operation. To $6,500. (g) Chief. East. 225-bed hospital, located in heart of resort area. $5,000.

EXECUTIVE HOUSEKEEPERS: (a) California. 325-bed hospital. 24 maids in dept. (b) East. 200-bed hospital, near N.Y. City. 25 employees in dept. at present. (c) Florida. 260-bed hospital, expanding. Excellent opportunity. (d) Middle West. 330-bed hospital. 21 employees in dept. (e) Pacific Northwest. 425-bed hospital in large city. (f) Southwest. 300-bed hospital. 50 employees in dept.

OCCUPATIONAL THERAPISTS: (a) Chief. Southwest. Large hospital. $5,400. (b) State University; psychiatric dept. Require one year's experience. (c) Middle West. Large state hospital. $5,400. (d) South. 200-bed hospital. Supervise planning of a new modern program. Excellent opportunity. $350 plus complete maintenance. (e) East. 100-bed hospital for psychiatric and neurology cases. $400.

MEDICAL RECORD LIBRARIANS: (a) Chief. South. 250-bed hospital in large city. $4,500 minimum. (b) Chief. Calif. 300-bed hospital $5,000. (c) Assistant to Chief. 250-bed hospital near San Francisco. Registration not necessary. (d) Chief. East. 285-bed hospital, near N. Y. city. Excellent staff of secretaries. $5,000 minimum. (e) Chief. Florida. 200-bed hospital. 4 clerks in dept. $4,800. (f) Chief. Middle West. 350-bed hospital in University City. 14 employees in record room. $6,000.

PHYSICAL THERAPISTS: (a) Chief. Middle West. Expanding dept. Complete charge of organization and purchasing. $500. (b) Middle West. 100-bed children's hospital. Prefer exp. in cerebral palsy. $450-$500. (c) Middle West. 225-bed teaching hospital. Dept. under construction. $450-$500. (d) Chief. West. Supervise 6 employees in 275-bed hospital. A 30-bed ward has been remodeled and equipped for the dept. $5,400. (e) East. Well-established cerebral palsy center in city of 70,000. $5,000. (f) Full-time teaching position in university school of physical therapy. $5,000 minimum to start.

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write to us for an application—a postcard will do. ALL NEGOTIATIONS STRICTLY CONFIDENTIAL

OPERATING ROOM SUPERVISOR — Large teaching hospital with restricted staff of board-qualified surgeons. Extensive internresident training. University-affiliated school of nursing. Large volume complicated procedures including neuro., chest, and heart. M.D. anesthesiologists only. Highest qualifications and experience necessary. Career supervisor preferred. Salary upward from $450, depending upon background — open to the right applicant. O.R. staff of 20 personnel. West Coast—mild climate. Write Box HT-10, HOSPITAL TOPICS, 30 W. Washington St., Chicago 2, Ill.

nearest thing to a lifetime edge!

A scissors — any scissors — is only as good as its edge

R65 Dissecting Scissors — another development pioneered by V. Mueller & Company — have sharp, tough, clean-cutting TUNGSTEN CARBIDE edges which last and last. Actually the nearest thing yet to a lifetime edge.

Tungsten carbide alloy has long since proved its surgical mettle in so-called "diamond jaw" needle holders. This valuable inlay, tough enough to score steel needles, provides similar strength and durability in these fine scissors to cut fascia, muscle, peritoneum, scar tissue, cartilage, uterus, ligamentous tissue, even silk and catgut suture materials — and cut them easily, cleanly, day in and day out.

Make sure your surgical trays include these better scissors that cut — always. Requisition them today!

MUELLER R65
TUNGSTEN CARBIDE EDGE DISSECTING SCISSORS

SU-1803	Mayo Dissecting, Straight, 5½"
SU-1804	Mayo Dissecting, Straight, 6¾"
SU-1813	Mayo Dissecting, Curved, 5½"
SU-1814	Mayo Dissecting, Curved, 6¾"
MO-1601	Metzenbaum Tonsil Scissors, 7"

Armamentarium

V MUELLER & CO.
330 South Honore Street
Chicago 12, Illinois

Dallas • Houston • Los Angeles • Rochester, Minn.

Review of Hospital Law Suits

When is Hospital Charitable?

By Leo Parker, Attorney at Law

• What is a legal and dependable rule to determine when, and under what circumstances, a hospital is lawfully charitable?

The higher courts consistently hold that immunity from liability upon the ground of being a public charity is an affirmative defense. Therefore, the burden of establishing the eleemosynary character of the institution is upon the party asserting that defense. See Walsh v. Sisters of Charity of St. Vincent's Hospital, 47 Ohio App. 228.

All higher courts agree that hospitals may or may not be public charities. The articles of incorporation are *prima facie* evidence of the character of the corporation as a charitable institution, but such *prima facie* evidence may be rebutted by evidence that in fact the corporation has not lived up to its chartered objects. See Benton County v. Allen, 170 Or. 481; Hamilton v. Corvallis General Hospital Association, 30 P. (2d) 9; and White v. Central Dispensary and Emergency Hospital, 99 F. (2d) 355, 119 A.L.R. 1002.

In Corporation of Sisters of Mercy v. Lane County, 261 P. 694, 698, the court stated:

"'The test which determines whether a hospital is charitable or otherwise is its purpose; that is, whether it is maintained for gain, profit, or advantage, or not.'"

For illustration, in Ackerman v. Physicians and Surgeons Hospital, 298 Pac. (2) 1026, the testimony showed that a woman named Ackerman, while a patient in the Physicians and Surgeons Hospital, sustained severe injuries which she alleged resulted from negligence of the attendants at the hospital.

The lower court held that she could recover heavy damages from the hospital if the testimony proved that the hospital was not a charitable institution. The testimony showed that the hospital corporation was incorporated as a charitable nonprofit corporation. There were 15 doctors, physicians, etc., who advanced $170,000 to start the hospital. This amount was to be repaid them sometime in the future.

No salaries were paid to the staff, but, of course, salaries were paid to employees, nurses, etc. During the 15 successive years the $170,000 was repaid from the hospital's profits. However, no dividends had been paid. The income over and above operation expenses was used for better patient care, equipment, buildings, or such charity as the hospital extended.

A provision in the bylaws vested lifetime control in the founders and allowed them to designate their successors by will. In respect to this clause, the higher court held that these elements are of valuable private advantage which a jury might consider in determining whether the hospital was operated for private advantage, or as a purely charitable hospital.

Furthermore, it was argued that although the hospital is operated without pecuniary profit, yet there is a definite gain or advantage accruing to the founding members by reason of the existence of the corporation—among other things, the assurance of a lifetime opportunity to practice their chosen profession in a modern metropolitan hospital as well as accessibility to the facilities, prestige, and security necessarily flowing from association with such an institution. Thus, there was one argument against the hospital being purely charitable and without profit.

Although the testimony showed that the total value of gifts, donations, bequests, etc., received by the hospital corporation since its creation in 1945 had been very small, yet the higher court held that the hospital corporation was not lawfully a charitable institution, and that it must respond in damages, the same as hospitals operated for profit, for injuries to patients. The court said:

> **"There is but one issue before us for decision, i.e., is the defendant (Physicians and Surgeons Hospital) in fact a charitable institution? We have not undertaken to set forth all the facts from whence a jury might infer that the defendant was not a charitable institution . . . but the defendant hospital maintains no charity wards. It charges the 'going rate' for all its services. There is charged off as bad debts about $25,000 a year. But the mere failure to collect from some of its patients is not sufficient to convert a private corporation into a charitable institution."**

LAW IS VARIED

A few weeks ago a higher court rendered an important decision to the effect that a charitable hospital is not ordinarily liable for injuries to a patient caused by negligence of an employee. However, this court indicated that the charitable hospital may assume liability if its officials hire incompetent help or retain in its employment incompetent employees who negligently injure a patient.

In Jones v. Baylor Hospital, 284 S. W. (2d) 929, the testimony showed that the Baylor Hospital is a charitable hospital—in fact, it takes only patients who are unable to pay for hospital services.

A patient named Jones sued the Baylor Hospital for heavy damages, alleging that his injuries were caused by the negligence of a nurse employed by the hospital.

The higher court refused to hold the hospital liable, and explained that a charitable institution is exempt from liability for injuries to its patients caused by negligence of its employees unless it is shown that the hospital officials were negligent in hiring or retaining the employee whose negligence caused the injury.

This court went on to explain that although a charitable hospital is not, under ordinary circumstances, liable in damages for injuries to a patient caused by negligence of

(Continued on next page)

its employee, it may be held liable if the patient proves that the negligent employee was retained in employment after the hospital officials should have known, by ordinary diligence, that the employee was incompetent. This court said:

"The court sustained appellee's (Baylor's Hospital's) special exceptions on the ground that appellee, being a charitable institution, is exempt from liability for injuries to its patients caused by negligence of its employee unless it is shown that it was negligent in hiring or retaining said employee."

CAN GO THROUGH RED LIGHT

A reader asks: "Is the driver of an emergency vehicle, as an ambulance, responsible for a collision when going through a red light or stop sign at a street intersection?"

According to a late higher-court decision, the driver of a private vehicle cannot avoid responsibility for a collision with an ambulance by testifying that he did not see the ambulance, or hear its siren, when it was going through a red light.

In Hardy v. Gilbert, 42 So. (2d) 158, the testimony showed that an ambulance was making an emergency run. Its red emergency warning light was blinking and its siren sounding continuously. When the ambulance reached a street intersection, the driver ran through a red stop light. The driver of an automobile dealer's car did not hear the siren and entered the intersection. A serious collision resulted, causing considerable damage to both vehicles.

In subsequent litigation the higher court held the automobile dealer's driver liable for the accident, and said:

"There is no doubt that the ambulance had its warning lights blinking and its siren sounding as proven by the two police officers who saw the collision . . . The plaintiff was chargeable with the knowledge that under the law an ambulance could, under certain conditions, proceed against a traffic signal or stop sign. The siren was heard by the two traffic officers and there was no reason why the plaintiff (dealer's driver) should not have heard it also. Under the law he is chargeable with hearing what he should have heard."

LIABILITY FOR ANESTHETIST

Considerable discussion has arisen from time to time over the legal question: Is a hospital corporation liable in damages for injuries caused a patient by an anesthetist?

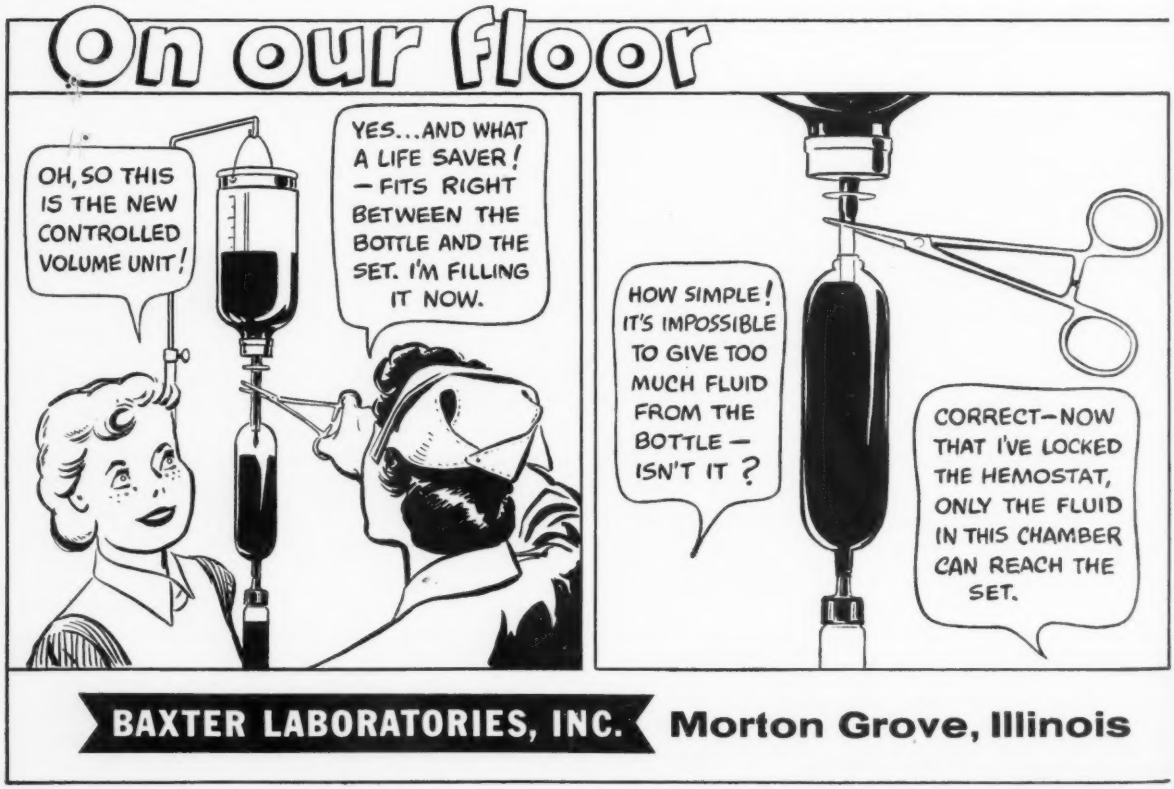
A few weeks ago a higher court answered this legal question in the affirmative—if the testimony shows that the anesthetist was negligent, and inexperienced in this work.

In Huber v. Protestant Deaconess Hospital, 133 N. E. (2d) 864, Huber sued the Protestant Deaconess Hospital for $85,000 damages on the basis of an improperly administered spinal anesthetic.

In subsequent litigation, the higher court held that if the testimony showed that the anesthetist employed by the hospital was reasonably qualified, reputable, and licensed, the hospital was not liable for negligent acts in administration of anesthesia.

In this respect, the court said:

"Certainly it would be unjust to hold a family physician responsible for negligent acts of a surgeon whom he might recommend. . . . The duty of a hospital corporation, in respect to physicians and surgeons, would be complied with by using reasonable and ordinary care to employ reasonably qualified, reputable, licensed physicians, and in such cases the physicians or surgeons are independent contractors."


On our floor
OH, SO THIS IS THE NEW CONTROLLED VOLUME UNIT!
YES...AND WHAT A LIFE SAVER! — FITS RIGHT BETWEEN THE BOTTLE AND THE SET. I'M FILLING IT NOW.
HOW SIMPLE! IT'S IMPOSSIBLE TO GIVE TOO MUCH FLUID FROM THE BOTTLE — ISN'T IT ?
CORRECT—NOW THAT I'VE LOCKED THE HEMOSTAT, ONLY THE FLUID IN THIS CHAMBER CAN REACH THE SET.
BAXTER LABORATORIES, INC.
Morton Grove, Illinois

PERSONALLY SPEAKING

(Continued from page 51)

Sister Maureen, R.S.M.—has been appointed administrator, Mercy Hospital, Bay City, Mich., succeeding **Sister Mary Maurita, R.S.M.** Sister Maureen was formerly administrator, Mercy Hospital, Cadillac, Mich.

Sister Mary Maurita—has been appointed administrator, St. Mary's Hospital, Grand Rapids, Mich.

Sister Mary Rene, R.S.M.—has been appointed administrator, St. John's Hospital, St. Louis, Mo., succeeding **Sister Mary Brendan, R.S.M.**, who has been transferred to St. John's Hospital, Springfield, Mo.

Sister Mary Robert, R.S.M.—has been appointed director, school of nursing, St. John's Hospital, St. Louis, Mo.

Sister Mary Theresa—has succeeded **Sister Mary Urbana** as administrator, St. Joseph's Hospital, Joliet, Ill.

Sister Mary Vivian—has been named administrator, Hibbing (Minn.) General Hospital, succeeding **Sister M. Assumpta.** Sister Vivian was formerly administrator, Miners' Hospital, Crosby, Minn.

Sister Marybelle Leick—has been appointed administrator, St. Mary's Hospital, Duluth, Minn., succeeding **Sister Mona.** She was formerly director, medical technology laboratory.

Sister Miriam Dolores—has become administrator, Mt. Carmel Hospital, Columbus, O., succeeding **Mother M. Constantine.** Sister Miriam Dolores was formerly acting director, St. John's Hickey Memorial Hospital School of Nursing, Anderson, Ind.

Sister Theofreda—former director, nursing service, St. Mary's Hospital, Duluth, Minn., has become administrator, Miners' Hospital, Crosby, Minn., succeeding **Sister Vivian.**

Robert E. Slayton,—has been appointed director, medical education, St. Luke's Hospital, Chicago.

Don Sprouse—has been appointed administrator, Lancaster (Wis.) Memorial Hospital, succeeding **H. E. Koss,** who has resigned.

Roger Starn—has become assistant administrator, St. Luke's Hospital, St. Paul, Minn. He was formerly assistant administrator, Good Samaritan Hospital, Portland, Ore.

(Continued on page 60)

MARY A. JOHNSON ASSOCIATES

AGENCY

11 West 42 Street, New York 36

Lackawanna 4-1565

Mary A. Johnson, Ph.D., Director

Our careful study of position and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situation, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

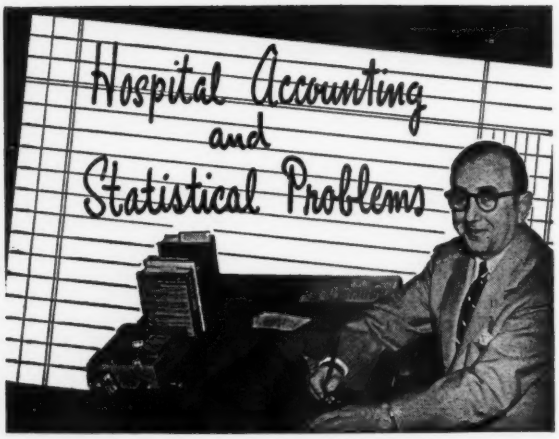
ANESTHETIST-NURSE—for 36-bed modern hospital located in a pleasant mid-western town of 5,000. Two weeks vacation and 12 days sick leave per year. Salary open. Write Personnel Office, Sparta Community Hospital, Sparta, Ill.

THAT'S REALLY GREAT. YOU DON'T HAVE TO KEEP WATCHING IT EVERY MINUTE.
THIS LITTLE DEVICE WILL SAVE US HOURS! IT WORKS WITH EITHER SOLUTION OR BLOOD — AND IT'S STANDARD PRACTICE FROM NOW ON.

ESPECIALLY USEFUL IN PEDIATRICS, the R36 insures utmost safety and accuracy of solution or blood administration... permits infusion in increments of approximately 50 cc. Easily fitted between bottle and administration set... conserves nursing time... expendable ... nontoxic... nonpyrogenic... economical.

Trav ©

pioneering parenterals for a quarter century



By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

Q. We would like to know the trend in regard to charges for surgical dressings. Do most hospitals make a separate charge for such supplies, or do they include it in an overall room and board and nursing charge? What is the general procedure with regard to special trays used for treatment: i.e., lumbar puncture, venous pressure, bone marrow, and cut-down set trays?

A. With the exception of routine drugs and medications, we find hospitals making special charges for all other services, particularly in cases which have heavy drainage and in which extra packs are required. Charges for special trays are also listed separately.

Many administrators have advised us that because of third-party reimbursements, which often include an indemnity portion for room and board and full reimbursement for ancillary services, the loss to the hospital would be substantial if they did not list these services separately. We have further been advised that hospitals are listing room charges separately from board and routine nursing care as an aid in explaining the cost of a hospital bill to the public.

Where mechanical equipment is used for hospital billing, a separate key has been installed to list these two items.

* * *

Q. We have recently engaged a controller in our hospital and would appreciate any guidance you can give us in defining the responsibilities of that position—telling how the controller fits into the organizational plan of the hospital and also to whom he is directly responsible.

A. There appear to be several definitions of the position of controller in accounting textbooks. The following excerpt was prepared from the pamphlet issued by the Controllers Institute of America and amended to apply to the hospital activity as differentiated from commercial enterprises.

(1) To establish, coordinate and maintain, through authorized management, an integrated plan for control of financial operation. Such a plan would provide, to the extent required, cost standards, expense budgets, income forecasts, and programs for capital investment and financing, together with the necessary procedures to effectuate the plan.

(2) To measure performance against approved operating plans and standards, and to report and interpret the results of financial operations to all levels of management and to the board of trustees. This function includes the design, installation, and maintenance of accounting records and cost systems, the determination of accounting policy, and the compilation of statistical records as required.

(3) To measure and report on the financial objectives of the hospital and on the effectiveness of its policies, organizational structure, and procedures in achieving those objectives. This includes consulting with all segments of management responsible for policy or action concerning any phase of hospital operation as it relates to the performance of this function.

(4) To report to governmental agencies, or subdivisions thereof, and related hospital agencies, as required.

(5) To interpret and report on the effect of external influences on the attainment of these objectives. This function includes the continuous appraisal of the effect of economic and social forces and of governmental influences and third-party paying agencies on the financial operations of the hospital.

(6) To provide protection for the assets of the hospital. This function includes establishing and maintaining adequate internal control and auditing, and assuring proper insurance coverage.

As an employee of the hospital, the controller is directly responsible to the administrator. In many instances, depending on the size of the hospital, he may work with the treasurer of the board of trustees or the finance committee of the board in preparing the budget or in accounting for trust funds.

With respect to personnel, he is usually responsible for the accounting, admissions, and telephone employees. His duties include the preparation of hourly schedules for coverage and employment of these groups. The purchasing office and personnel are also included under the controller's supervision in many instances.

* * *

Q. Our hospital has recently purchased a second mortgage at a discount with funds from nonrestricted endowments, i.e., restricted by board and not by donor. The face amount is $52,000, and it is due in quarterly installments of principal and interest maturing in 1962. We paid $44,000 for the mortgage. The difference was credited to the "Profit and Loss on Sale of Investment" account. Is this a proper entry, or is an adjustment indicated?

A. If you pick up the difference as earnings at this time and the mortgage payments are not met, you would have a financial problem as well as an accounting problem. We would recommend that the unearned income be accrued on a pro-rata basis during the next five years on your books of account. With respect to balance sheet presentations, the unearned balance of the mortgage should be shown as deferred income.

* * *

Q. Would you please advise how long we should keep charge tickets for hospital services that have been posted to patients' accounts?

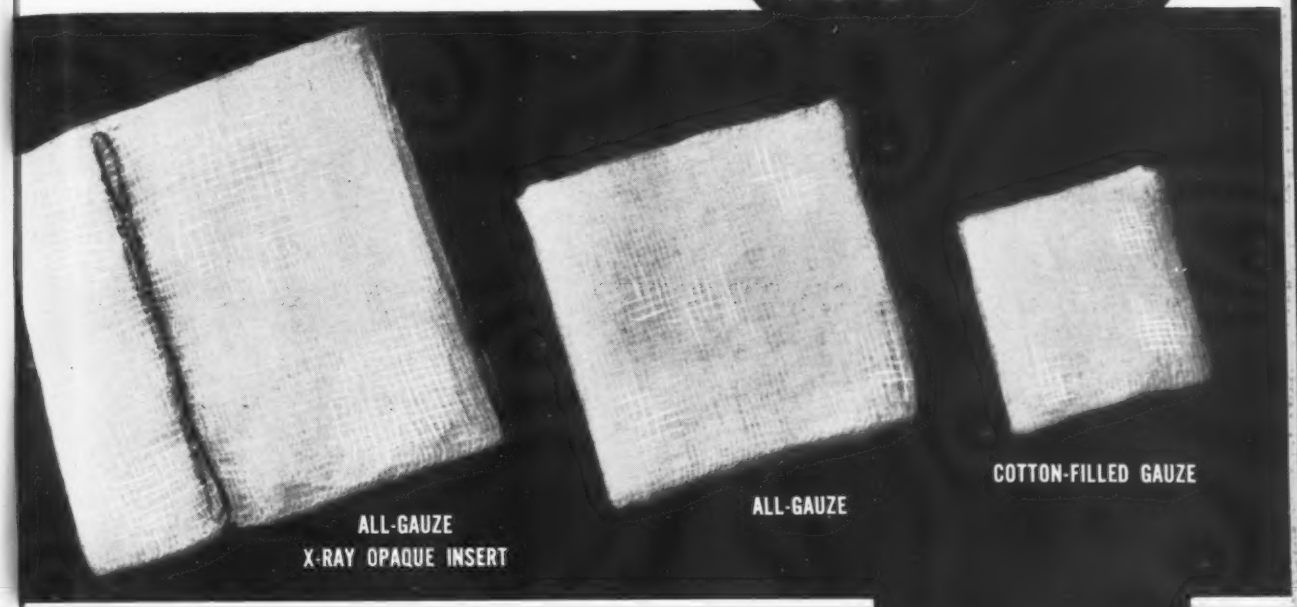
A. In a recent survey of hospitals, we found that charge tickets were kept an average length of two years. If detailed information is required, supporting data may be found on the patient chart. All prime financial records are kept for as long as the statute of limitations is in force in accordance with state law. This information can be obtained from a local attorney.

CAROLINA *Sponges*

3 KINDS

15 SIZES

100's OF USES



Carolina sponges are soft and pliable—absorbent and non-abrasive throughout—no hard or harsh corners. Meticulously made, economical.

All edges are carefully, neatly folded inside; no loose threads can escape. Carolina sponges are uniform and dependable.

Monofilament X-ray opaque string makes good clear pattern on plates from any angle. Meets hospital standards for safety, ease of use.

For greater economy outside the operating room, substitute Carolina cotton-filled sponges for all-gauze. The thin even layer of combed cotton is very absorbent. Convenient for pressure dressings as well as post-operative dressings and general wound care.

Write for samples, prices, complete information . . .

Carolina Absorbent Cotton Company

P.O. BOX 2176 · CHARLOTTE 1, N. C.

AROLA spital supp

manufactured where grown

HOSPITAL INDUSTRIES ASSOCIATION HIA

CAROLINA—

FOR ALL YOUR COTTON AND TEXTILE NEEDS!

Carolina your dependable source

for All Hospital Textiles . . .

- BATHMATS
- BASSINET LINERS
  - *pads*
  - *padding*
- BEDSPREADS
- BLANKETS
  - *Bath*
  - *Crib*
  - *Ether*
- CURTAINS
  - *curtain material*
- DRAPERY MATERIAL
- LAUNDRY FELT
- LINEN MARKERS
- MATTRESS COVERS
- PIECE GOODS
  - *white and colored*
- PILLOWS
- PILLOW CASES
- PILLOW COVERS
- SHOWER CURTAINS
- SHEETS
  - *BED*
  - *CRIB*
  - *bleached*
  - *unbleached*
  - *percale*
  - *contour*
- SHEETING
  - *bleached*
  - *unbleached*
  - *jade green*
- TAPE
- TABLE LINENS
  - *tablecloths*
  - *napkins*
  - *tray covers*
- TICKING
- TOWELS
  - *terry*
  - *huck*
  - *absorbent*
  - *kitchen*
  - *name woven*
- TOWELING
- UTILITY FABRICS
  - *drill*
  - *twill*
  - *duck*
- WASH CLOTHS

HIA HOSPITAL INDUSTRIES ASSOCIATION

Whatever your needs—from a wash cloth to a bolt of drapery material—Carolina has it or can get it. **Your textile problems are our business.**

More important, Carolina has in stock a complete selection of grades—from service weights to luxury items, unbleached muslin to percale—to meet your individual requirements, *and your budget!*

A Carolina representative will be glad to show you samples, help you in any possible way.

Send for a complete Carolina catalog if you do not have one readily available—14-page section on textiles included.

IMPORTANT: Carolina carries only *branded* merchandise—your guarantee of dependable uniformity. High tensile strength, long wearing characteristics are inherent in products bearing the maker's own name.

Carolina Absorbent Cotton Co.

(Division of Barnhardt Mfg. Co.)

CHARLOTTE 1, NORTH CAROLINA

quality products of cotton since 1900

STRIP DRESSING

ALWAYS READY

when you need them

AUREOMYCIN Topical Products provide safe, high-concentration broad-spectrum action at the site of potential or existing infection... promote faster healing and virtually eliminate odor in burns, abscesses, surgical incisions, amputations, and other wounds.

where you need them

For hospital, office or emergency use, pre-sterilized AUREOMYCIN Topical Products are always ready for instant application... are established favorites for convenient, efficient topical antibiotic therapy.

POWDER

8" x 12" DRESSING

PACKING

AUREOMYCIN® DRESSINGS

CHLORTETRACYCLINE HYDROCHLORIDE

AUREOMYCIN Chlortetracycline—Impregnated Gauze Products—containing 2% Chlortetracycline Hydrochloride in a special, nonadherent, water-absorbent base—are available as—Strip Dressing—½" x 72", 2" x 108"; in glass jars. 8" x 12" Dressing—in individual aluminum foil envelopes. Packing—½" x 24", 1" x 36", and 2" x 36"; in glass jars.

AUREOSURGIC® Surgical Powder—Containing 50 mg. Chlortetracycline Hydrochloride per gram in a soluble base—is available in shaker-top bottles of 20 Gm.

SURGICAL PRODUCTS DIVISION
AMERICAN CYANAMID COMPANY
DANBURY, CONNECTICUT

TRADE TOPICS . . .

After gathering $1,000 over a four-year period, the 28 members of a club made up of General Electric employees at Hanford, Wash., are contributing needed equipment to the three hospitals in the area. Above, discussing equipment to be presented to Kadlec Methodist Hospital, Richland, Wash., are (l. to r.): E. H. Hansen, Shipman Surgical Co., Seattle; R. E. Heinmeyer, club president; Horace Turner, Kadlec administrator, and A. T. Newborne, club treasurer. The other two hospitals which will benefit are Our Lady of Lourdes Hospital, Pasco, Wash., and Kennewick (Wash.) General Hospital.

Lehn & Fink Purchases National Laboratories

Lehn & Fink Products Corp. recently purchased National Laboratories, Inc. of Toledo, O., thus expanding into industrial sanitation chemical products.

No changes are contemplated in the management of National Laboratories. Lisle C. Van Nest will continue as chief executive officer.

News Briefs

Will Ross, Inc.—has opened an office and warehouse at 808-14th Ave., S.E., Minneapolis, Minn.

* * *

L. James Lewis, Ph.D.—has been appointed to the research staff, The National Drug Co. Before becoming a member of the Salk polio vaccine team at the University of Pittsburgh, he was assistant director of biological research at National Drug.

Mead Johnson's Mexican Subsidiary Opens Plant

Mead Johnson de Mexico, S.A., Mexican subsidiary of Mead Johnson & Co., has opened its new offices, plant, and warehouse in Mexico City.

Except for two U.S. citizens, including Alfred J. Torrey, president of Mead Johnson de Mexico, the plant will be staffed entirely by more than 150 Mexican nationals.

Chas. Pfizer Acquires Morton-Withers Co.

The acquisition of Morton-Withers Chemical Co., Greensboro, N.C., by Chas. Pfizer & Co., Inc., has been announced.

Morton-Withers, producer of chemical specialties, will be operated as a Pfizer subsidiary.

Schenley Laboratories Changes Name

The pharmaceutical affiliate of Schenley Industries, Inc., has changed its corporate name from Schenley Laboratories, Inc., to SchenLabs Pharmaceuticals, Inc.

* * *

Dennis D. Miller—has been appointed manager for district 6 of the Norwich Pharmacal Co.'s west central division. Chicago will be his base.

* * *

Thomas J. McLaughlin—is now manager, Eaton Laboratories' district at Dallas, Tex., succeeding **W. C. Nelson** new Midwestern division manager.

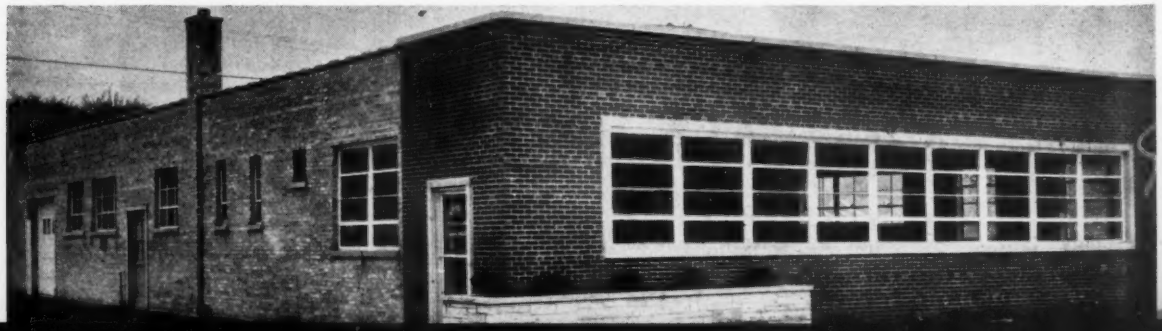
* * *

Amcoin Corp.—has moved executive and sales offices from the Chrysler Building, New York City, to Pine Meadow, Conn.

* * *

Frederick J. Cavanaugh—is assistant to the president, Wyeth International Ltd. He was formerly manager, Colombian office, E. R. Squibb & Sons.

Professional Tape Co., Inc. has recently occupied the above offices in Riverside, Ill. In addition to billing, advertising, production, and shipping departments, a new safety department will feature a complete library on personnel infections in hospital and laboratory.



The Burdick Corp. has celebrated its 45th anniversary with completion of a new building housing offices and the engineering department, in Milton, Wis.

Zimmer Names Director of Latin-American Sales

Paul M. White, Jr. has been appointed director, Latin - American sales, Zimmer Export Corp., subsidiary of Zimmer Mfg. Co. He has been a Zimmer sales distributor in southern states.

C. R. Bard Names Two On Sales Staff

New members of the sales staff at C. R. Bard, Inc., are John Frederick Willits II and A. Theodore Schuessler, Jr.

Willits

Schuessler

Willits, not yet assigned to a territory, will represent the third generation of the Willits family in the Bard firm. Schuessler will be assigned to Michigan, Indiana, and Kentucky.

Walker Labs Announces Recent Appointments

Appointments by Walker Laboratories, Inc., include the following: Joseph F. Pendrak, former division manager for New England and Middle Atlantic states, now general field sales manager; Vincent M. Cioffi, former supervisor of central states district, now Midwestern division manager, and Gardner T. Smith, former California and Arizona supervisor, now West Coast division manager.

Don Baxter, Inc., Makes New Appointments

Arthur Cherkin, Ph.D., vice-president and director of research, Don Baxter, Inc., will head the company's newly-created international division.

Cherkin

Corcoran

A research consultant to Baxter, William H. Corcoran, Ph.D., has been appointed vice-president and director of a newly formed scientific division.

Hauserman Names Two in Management Posts

Kenneth A. Hawkins has been named sales manager for the central United States by E. F. Hauserman Co.

Hawkins

Tyrer

Succeeding him as Chicago branch manager is James W. Tyrer, former manager of the Cincinnati office.

(Continued on next page)

5 REASONS FOR BUYING L/L. INTERS SYRINGES

L/L INTERS assure perfect interchangeability.

L/L INTERS provide uniform compression from tip to top, prevent back flow.

L/L INTERS satin-smooth grind eliminates high-spots, prolongs syringe life.

L/L INTERS are guaranteed against breakage during sterilization, fading scales or loss of locks.

L/L INTERS are priced to please:

	ALL GLASS	LUER-LOCK OR METAL TIPS
2 cc.	$16.80 doz.	$19.60 doz.
5 cc.	24.00 doz.	27.00 doz.
10 cc.	30.00 doz.	33.00 doz.
20 cc.	39.00 doz.	42.00 doz.

Less Hospital Discount

For those who prefer Non-Interchangeables, Lurline offers quality syringes at a budget price.

Ask Your Dealer

LURLINE PRODUCTS COMPANY

Woodmere, L. I., N. Y.

Distributed in Canada by
The J. F. Hartz Company

TRADE TOPICS continued

E. Lee Bullington—has been appointed hospital sales service field manager, Smith, Kline & French Laboratories. He has been Eastern region hospital service manager.

* * *

The Colson Corp.—has moved its greater New York sales office from Union City, N.J., to 215-4th Ave., New York City.

* * *

Lyman R. Fink, Ph.D.—has been appointed general manager, x-ray department, General Electric Co. Former manager of research application, General Electric Research Laboratory, Schenectady, N.Y., he succeeds **John H. Smith**, who has resigned to join the University of Wisconsin-Milwaukee School of Business Administration.

* * *

Bernard D. Duffy—has been named to succeed **Norman J. Lebhar** as resale products manager, Lily-Tulip Cup Corp.

* * *

Edward L. Carlson—advertising manager, Oakite Products, Inc., has been placed in over-all charge of the company's informational efforts.

NOW AVAILABLE WITH
Color-Coded Caps
THAT TELL SIZE AT A GLANCE
Sterilon
NEEDLE TAINERS
Edge Under Needletainer Cap is Sterile, Permitting Pouring of Needle on to Sterile Field. Or, Syringe May Be Inserted for attaching Sterile Needle Aseptically and Withdrawing Ready for Use.
TAKE OFF CAP
INSERT SYRINGE
TWIST AND REMOVE
Sterilon Needletainers are now color-coded to needle size and gauge at no extra cost to facilitate sorting in central supply and size selecting when ready for use.
Unbreakable Needletainers protect needle from damage during and after sterilization. Compact size permits easy storage or carrying. Can be used and re-used for keeping needles sterile as long as cap fits tightly. (Pat. Pending)
Ask your Hospital Supply Dealer for free 8½ x 11 inch color code Needletainer Wall Chart.
If Your Hospital Supply Dealer Can't Supply Needletainers, Contact
Quality is Our Cornerstone
Sterilon CORPORATION
500 NORTHLAND AVE., BUFFALO 11, N.Y.

PERSONALLY SPEAKING

(Continued from page 55)

Mrs. Maude Swartzendruber — has been appointed education director, Mennonite Hospital School of Nursing, Bloomington, Ill., succeeding **Mrs. Marlene Genung.**

Per-Olaf Therman, Ph.D.—has been appointed director, experimental research and clinical investigation, Pennsylvania Hospital, Philadelphia.

Eugene E. Tillock — has been appointed assistant administrator, Highland View Hospital, Cleveland, O.

Jimmie L. Warren—has been appointed business manager, Jackson Hospital, Marianna, Fla., succeeding **Charles Richardson,** now in the Army.

Olga Waslyk—has been appointed administrator, dietary department, Good Samaritan Hospital, Portland, Ore.

Ernest Williams—has been named assistant administrator, Carraway Methodist Hospital, Birmingham, Ala. He was formerly administrator, Cullman (Ala.) Hospital.

Isabella N. Williams—has become administrator, Washington County Hospital, Chipley, Fla., succeeding **Laurel M. Jones,** who has become administrator of a Columbia, Miss. hospital.

Lacy Williams—has been appointed assistant administrator, St. Luke's Hospital, St. Louis, Mo. He was formerly associated with North Carolina Baptist Hospital, Winston-Salem, N.C.

William E. Worchester, Jr.—has been appointed administrator, Valley Hospital, Ridgewood, N.J. He was formerly assistant director, New England Deaconess Hospital, Boston.

VA Appointments

Buford Ardoin— has been appointed assistant chief nursing service, VA Hospital, Biloxi, Miss. (Gulfport Division), where he was formerly acting chief.

James H. Blake— has been appointed chief, special services, VA Hospital, Marion, Ill., succeeding **Fred Peters,** who was transferred to Palo Alto, Calif. Mr. Blake was formerly with the VA Hospital, Houston, Tex.

Benjamin F. Jackson, M.D.—has been appointed manager, VA Hospital, Bedford, Mass., succeeding **Winthrop Adams, M.D.,** who has retired. He was formerly manager, VA Hospital, Tomah, Wis.

Charles S. Lucas—has been named area director, administrative services,

(Continued on page 62)

If you're → throwing away 10% of your adhesive

(BECAUSE IT WON'T COME OFF THE ROLL)

switch to New Curity Adhesive and put an end ← to waste

...BECAUSE CURITY ADHESIVE UNWINDS WITH A GENTLE PULL SO ALL TAPE COMES OFF THE ROLL

Are you getting only 9 yards of tape from a 10-yard roll? Wasting the last 10 per cent because it won't come off the roll?

Then switch to New Curity Adhesive—the one that unwinds with the same gentle pull right to the end of the roll.

And here's another Curity economy: Famous quality Curity adhesive stays fresh. It's the easy-to-handle adhesive that really *sticks*—even after months on your shelf.

Ask your Curity representative for a demonstration.

NEW Curity ADHESIVE

BAUER & BLACK

Division of The Kendall Company

NEW DISCOVERY

Saves Plumbing Bills Cleans Instantly

CHICAGO — Sept. 1st — Homes, Sanitariums, Hospitals, Offices, including apartments are constantly having trouble with clogged-up pipes which proves expensive in Costly Plumbing Bills—

But now—using Water Impact and Air Pressure, here is a new unit called the **Plumber's Flushing Gun**, which cleans all lines up to 100 ft. It will open any number of bends in pipe. Yet anyone can operate this new gun, which triggers easily.

TOILETS, URINALS, SINKS, and FLOOR DRAINS clogged with paper, grease, rags, sand, and other debris can be cleared with one or more shots from the gun, saving the owner, the Gun's price the first time it is used. This new Flushing Gun may be used on any ½ to 6 inch waste pipe including Bathtubs, Floor Drains, Hot Water Pipes, House-to-Street Sewers, Septic Tanks, and Urinals. Obstructions melt away INSTANTLY when struck by the hammer like blow of this new unit.

This New Flushing Gun is offered on 30 Days Free Trial. BUT MOST IMPORTANT IS THIS—What is this Tool worth in **Costly Plumbing Bills** Saved in your Home or Hospital. For your own good—Tear this Ad out now and write your name and address beside Ad for Free Booklet. No Agent will call—Obey that urge, mail now or write postcard. (Chicago Phone Kildare 5-1702) **MILLER SEWER TOOLS, DEPT. HT-5, 4638 N. CENTRAL AVE., CHICAGO 30, ILLINOIS.**

Free Catalog on Electric and Hand Sewer Equipment Write to Above Address

Electric Unit cleans up to 500 ft.

PERSONALLY SPEAKING

(Continued from page 60)

Columbus (O.) VA area medical office. He was formerly assistant manager, VA Hospital, Portland, Ore.

Virgil I. McIntyre—has become assistant manager, VA Hospital, Portland, Ore., succeeding **Charles S. Lucas.** Mr. McIntyre was formerly assistant manager, VA Hospital, Marion, Ill.

Benedict Nagler, M.D. — chief, VA neurology division, Washington, D.C., has been appointed superintendent, Lynchburg Training School and Hospital, Colony, Va.

Frank J. Schaffer, M.D. — formerly chief, physical medicine and rehabilitation service, VA Medical Teaching Group Hospital, Memphis, Tenn., has been appointed chief, program development in the same service, Washington, D.C.

VA Nursing Appointments

Louise R. Camden — has been appointed chief, nursing service, VA Hospital, Chillicothe, O. She formerly held a similar position at VA Hospital, Northport, N.Y.

Theda Fox — has become assistant chief, nursing education, VA Hospital, San Francisco. Prior to transfer she held a similar position at VA Hospital, Syracuse, N.Y.

Rosemary Gartland — has been appointed chief, nursing service, Albany (N.Y.) Hospital. She formerly held a similar post at VA Hospital, Hines, Ill.

Mary Harper—has become assistant chief, nursing education, VA Hospital, Los Angeles (Brentwood Division). She formerly held the same position at VA Hospital, Battle Creek, Mich.

Sarah Markle—has become assistant chief, nursing education, VA Hospital, Erie, Pa. Prior to transfer she was an instructor, VA Hospital, Pittsburgh.

Ruth Mathews—has become assistant chief, nursing education, VA Hospital, Battle Creek, Mich., where she was formerly an instructor.

Cleone Stump—has become assistant chief, nursing education, VA Hospital, Fort Bayard, N.M. Prior to transfer she was assistant chief, nursing service, Marion, Ind.

Vera Sweany—is assistant chief, nursing education, VA Hospital, Vancouver, Wash. Prior to transfer she was a supervisor, VA Hospital, Dayton, O.

Myra Thomas — has been appointed chief, nursing service, VA Hospital, Hines, Ill. She formerly held a similar post at Albany, N.Y.

Joseph Wisherd — has been named assistant chief, nursing service, VA Hospital, Canandaigua, N.Y., where he was formerly acting assistant chief.

Deaths

Jacob L. Bubis, M.D.—head, department of obstetrics and gynecology, Mount Sinai Hospital, Cleveland, for 25 years, died July 24.

Arthur Capitanelli—37, assistant administrator, Presbyterian-St. Luke's Hospital, Chicago, died August 30.

Bruce W. Dickson—36, past president, Mid-West Hospital Association, and administrator, Bethany Hospital, Kansas City, Kan., died August 11.

William J. Dieckmann, M.D.—59, expert on diseases of pregnancy, former president, Chicago Gynecological Society, and former chief of staff, Chicago Lying-in Hospital, died August 15.

Edgar C. Hayhow, Ph.D.—63, director, East Orange (N.J.) General Hospital, died August 23. He was formerly director, Paterson (N.J.) General Hospital, 1930-46, and had been president, American College of Hospital Administrators, in 1948. The author of "Hospital Administration, A New Profession," he was a former AHA vice-president.

Richard Mackenzie—68, consultant on management for hospitals and social welfare agencies for several states, died September 8. He was a former managing director, Broad Street Hospital, and assistant superintendent, Lying-In Hospital, both in New York City.

George M. Ritchie — 64, comptroller, Jefferson Medical College, Philadelphia, died Sept. 8.

Carlson Succeeds Gersonde As Chicago Council Head

Wendell H. Carlson has been appointed executive director, Chicago Hospital Council, an organization of 67 hospitals serving the Chicago metropolitan area.

He succeeds James R. Gersonde, who has resigned because of ill health.

Mr. Carlson will assume duties as soon as he can be released from his present post as administrator, Englewood Hospital. Stanley P. Farwell, chairman of the council's board of directors, will serve as acting executive director until Mr. Carlson takes over.

The new council executive director is president of the council and was formerly president, Illinois Hospital Association (1955). He is an Illinois delegate to the American Hospital Association and a fellow, American College of Hospital Administrators.

DOROTHEA BOWLBY ASSOCIATES

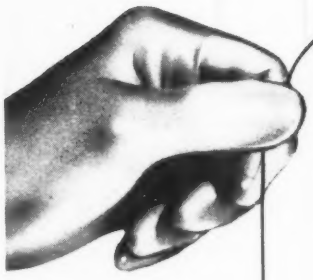
A specialized employment service for medical and hospital personnel

8 S. Michigan Ave., Suite 618
Chicago 3
ANdover 3-5293

Dorothea Bowlby, Director

Confidential listings (men and women) for administrators, personnel directors, business managers, dietitians, physicians, directors of nurses, therapists, pharmacists, medical record librarians, anesthetists, public relations directors, housekeepers, bacteriologists, biochemists, anesthetists, medical technologists, x-ray technicians, food service managers.

All inquiries are strictly confidential.



OHIO

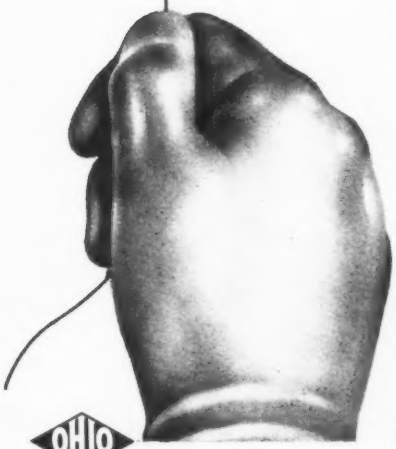
TENSO-*Pli*®

CATGUT SUTURES

guaranteed

STRENGTH

when strength counts



TENSO-*Pli* sutures exceed U.S.P. strength requirements by 50% or more. Every lot of size 2/0 material passes the U.S.P. test for size 0. Every lot of size 0 passes the test for size 1. This is not accidental, but the result of rigid testing. We are so sure of your satisfaction that *we have printed a written guarantee on each label*, together with the knot strength of each lot. When extra strength is a necessity, be sure . . . specify TENSO-*Pli*.

TENSO-*Pli* is the only surgical suture with individually formulated solutions for each size. This assures maximum pliability, resistance to fraying, and controlled absorption.

New Suture Catalog covering the entire Ohio Chemical line of surgical sutures and needles can be obtained by writing Dept. HT-10

"Service is Ohio Chemical's Most Important Commodity"

OHIO

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.

Madison 10, Wisconsin

Ohio Chemical Pacific Company, Berkeley 10, Calif.
Ohio Chemical Canada Limited, Toronto 2
Airco Company International, New York 17
Cia. Cubaña de Oxigeno, Havana
(All Divisions or Subsidiaries of Air Reduction Co., Inc.)

AIRCO

At the frontiers of progress you'll find **An Air Reduction Product** . . . **Ohio**: Medical Gases and hospital equipment • **Airco**: Industrial gases, welding and cutting equipment, and acetylenic chemicals • **Pureco**: Carbon dioxide (liquid, solid [Dry Ice]) • **National Carbide**: Pipeline acetylene and calcium carbide • **Colton Chemical**: Polyvinyl acetates, alcohols and other resins.

The GREATEST NAME in

New ¾ Safety Sides. Fully protect the restless patient, yet allow him to leave bed at foot if necessary. Durable chrome construction. Telescopic sides fold up and swing out of way when not in use. Quickly attached with clamp straps—no tools necessary.

SEE This Month's American Bulletin For NEW PRODUCTS and SPECIAL VALUES! IT'S ON ITS WAY TO YOU NOW!

Tomac

Suppliers of more than 15,000 products, hospital-proved for quality, efficiency and economy

CHICAGO • NEW YORK • ATLANTA • DALLAS • SAN FRANCISCO

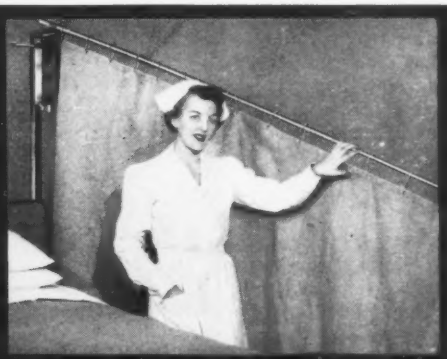
safety, comfort, and privacy for your patients...TOMAC!

The TOMAC products illustrated here are the successful result of careful research into *your* needs and *your* methods. Because of their superior performance under hospital working conditions, you can be assured that they will ease the work of your hospital personnel and bring greater comfort to your patients.

These four exclusive TOMAC products—¾ Safety Sides, Full Length Safety Sides, Cubicle Curtain, and Wall Lamp—all telescope and fold easily out of the way—all fulfill their functions with *greater efficiency* than any other similar products in the field.

Because of their *proven superiority*, they bear the TOMAC symbol—the symbol which is always your guarantee of unexcelled quality, service, *and* economy!

Full Length Safety Sides. Like the ¾ Safety Sides at left, they're lightweight and easy to handle, yet ruggedly built for years of hard use. Can be fitted to all standard beds. Easily telescoped and folded back.



Telescopic Cubicle Curtain. Curtain swings away from bed for patient examination. Spring hinge eliminates damage due to accidental pulling. Can be telescoped to ⅓ its length and folded against wall. In 5 pastel colors.

The PERFECT Wall Lamp. Ideal for reading and spotlight examination. Complete freedom of movement — shade can be rotated — arm is telescopic and also swivels at wall mount. Heat-proof lamp head is always cool.

American Hospital Supply *corporation*

GENERAL OFFICES · EVANSTON, ILLINOIS

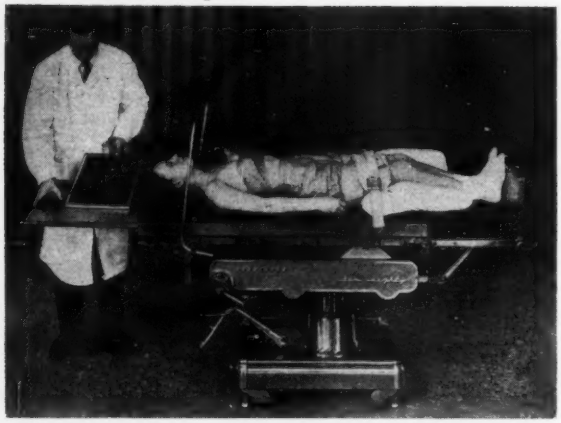
WASHINGTON • MINNEAPOLIS • KANSAS CITY • LOS ANGELES • COLUMBUS

BUYER'S GUIDE

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 72.

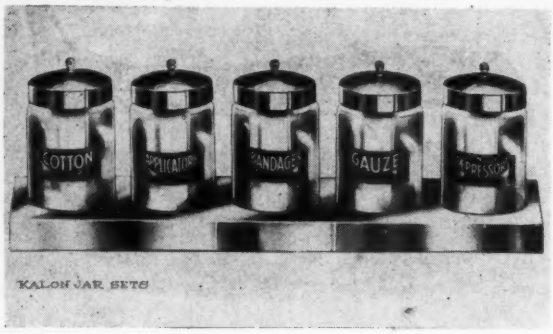
Evelyn Sebastian
Buyer's Guide Editor

800. Mattress pad



Cassette Tunnel Mattress pad No. 1835 permits precise radiography during operative procedures. Loading, positioning, and unloading accomplished from outside sterile field without moving patient, disturbing drapes, or interfering with surgical team. Pad is substituted for regular pad of American No. 1080 operating table before patient is brought in. Special spring lock on sliding tray permits cassette to be placed in any desired position from right to left-hand side of table while automatically centering it in lengthwise dimension of tray. Graduated positioning handle locates tray lengthwise of table at exact spot desired by surgeon. American Sterilizer Co.

801. Glass jars



Kalon jars, 7" high and 4" wide, are of hand-blown glass, with stainless steel covers and green-and-platinum labels permanently fired into glass. Labeled for gauzes, tongue depressors, bandages, cotton, and applicators. Protex jars, machine-made, to stand hard use. Both available singly or in sets of five, with or without matching stainless steel rack. Professional Specialties, Inc.

802. Portable cardio-encephalograph

Portable, two-channel electrocardiograph-encephalograph is designed to aid anesthesiologist in determining cardiac condition and depth of anesthesia continuously during surgery. Compact unit may be operated on 5-ft. stand above level of explosive anesthetic agents when used in the O.R. Paper flows down in a vertical plane, easily visible to anesthesiologist. Foot switch controls apparatus from distance. Permanent record lies flat, may be paged through like a book. Unbreakable pens. Gilson Medical Electronics.

803. Formula dispenser

New stainless steel formula dispenser simplifies formula preparation, cuts bottle-filling time by 50 percent, according to manufacturer. Dispenser holds 10½ qts. of formula for 84 4-oz. bottles. Formula is dispensed through a rubber latex tube with clamp which attaches to bottom of container. System eliminates complicated valves or stopcocks which may become a contamination problem. American Hospital Supply Corp.

804. Flame photometer

New flame photometer, with ½ sq. ft. bench area and case only 8½" wide, is smallest on market, manufacturer says. Has big-instrument repeatability, high thermal stability, is simple to operate. Advanced Instruments, Inc.

805. Medical isotope lab

New, low cost medical isotope laboratory is capable of providing versatile and basic instrumentation. Physician can perform thyroid diagnosis (1-131 uptake), localization of metastatic masses, localization of brain tumors, protein bound iodine determinations, and blood volume studies. Nucleonic Corp. of America.

806. Cancer accession register

Form R-105, cancer accession register, simplifies compilation of statistics. Book contains 100 pages for recording the accessioning of 2,500 patients having a proved primary cancer. Covers five years in an average hospital or clinic. Printed on white ledger stock, 12" x 12½", with 19 numbered columns across two pages. Physicians Record Co.

806a. Commode-chair

Plastic upholstered combination commode-chair fits into decor of room without embarrassment to patient. Has chrome arms and legs, baked enamel body. Upholstered seat hinged to body of chair so it can be easily lifted. Natural lacquer finish hardwood toilet seat, flush with top of metal chair body, can be raised for easy removal of baked enamel pot receptacle. Entire chair is washable. Arlington Medical Co.

807. Hip exerciser

Chick Hip Exerciser is made to fit any standard bed—wood or metal. Gives smooth, positive action. Upper unit mounted to main upright with roller bearings to give frictionless movements, and spring-loaded to provide necessary lift to suspend leg. Tension in spring can be adjusted by winding spool. Top bar may be locked in abduction position if desirable. Two narrow slings and one wide trough-like sling provided. Gilbert Hyde Chick Co.

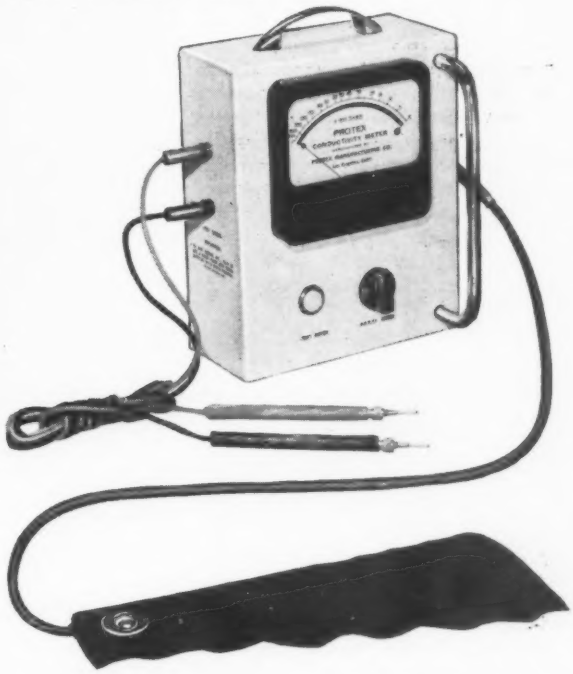
808. Oxygen analyzer

O.E.M. electronic oxygen analyzer permits frequent routine checking in electric oxygen therapy to insure maintenance of oxygen concentrations. Improves oxygen hood therapy. Prevents retrolental fibroplasia by controlling amount of prescribed oxygen given to premature infants. O.E.M. Corporation.

809. Gastric analysis

Diagnex-Blue unit, to aid in determining presence or absence of hydrochloric acid in the stomach, consists of packet with two grams of dye-resin containing approximately 100 mg. of azure A dye, and, in separate wrap, two tablets, each containing 250 mg. of caffeine sodium benzoate. In test, patient takes tablets and one hour later water containing the dye-resin complex. Each trade package of five or 50 test units holds a comparator for performance of the visual test. Advantages of test include accuracy, simplicity, speed, economy, and elimination of discomforts of intubation. Test also lends itself to large-scale cancer screening. Squibb & Sons.

810. Testing meter



"Protex" conductivity testing meter indicates the exact ohm resistance in 1000 ohms of every article tested. Features include portability and safety—it is operated off a 45-volt dry battery. Two plugs, a connecting cable, and contact prongs provided for testing appliances, etc. Conductive neoprene mat provided to test shoes. Fully approved by the California state fire marshal's office. Guaranteed for one year against defects in material or workmanship. Protex Manufacturing Co.

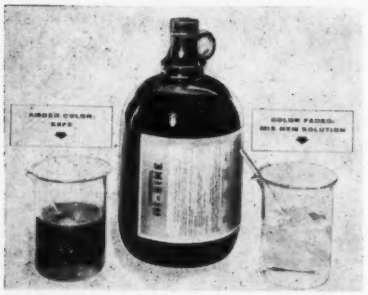
BUYER'S GUIDE

Continued

811. Transistorized ECG

"Model 300 Visette," completely portable, direct-writing ECG, weighs only 18 lbs., has two basic controls for operation; push-button grounding to aid elimination of AC interference; automatic amplifier-stabilizing action as lead selector knob is turned; automatic power shut-off when cover is closed; writing surface beneath chart for making notations; quick, easy chart reloading. Sanborn Co.

812. Detergent germicide



Hi-Sine, new iodine detergent germicide, kills tubercle bacilli, the polio virus, and other pathogenic bacteria. Nontoxic, nonirritating, does not sensitize. Rich amber color indicates Hi-Sine is being used safely according to manufacturer. When color fades, fresh solution is needed. Cleans, disinfects floors, dishes, thermometers, walls, utensils, even conductive flooring. Available in gallon containers. Huntington Laboratories.

813. Nonskid cartons

To promote safety in the lab stockroom, Fisher chemicals are now packaged in special non-skid cartons. Tiny welts in paperboard tops and bottoms of cartons help keep stacks in place on stockroom or reagent shelf. Fisher Scientific Co.

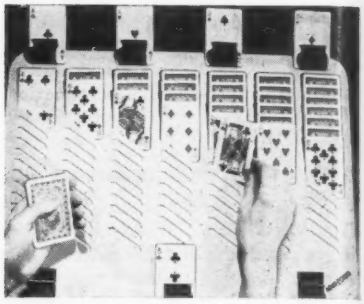
814. Syringe rack

Specially developed syringe racks of stainless steel wire are made to fit into CRC Labwasher, to permit syringe washing in that equipment. Racks come in two sizes. Each 5 cc. rack holds 114 5 cc. plungers or 70 5 cc. barrels. The 2 cc. racks hold 240 plungers or 114 2 cc. barrels. Two of each size can be accommodated in one washload, fitting into top section of Labwasher. Chemical Rubber Co.

815. Life-like prosthesis

Bettinger life-like prostheses provide new limbs for old, where lost through disease or accident, or congenitally missing. Also have many uses in facial disfigurement. Plastic used in prostheses matches skin color, has excellent detail, pliability, depth. Prosthesis assumes body temperature, feels warm and life-like. Light, durable, and can be washed with ordinary soap and water. Lillian Bettinger.

816. Bedside solitaire

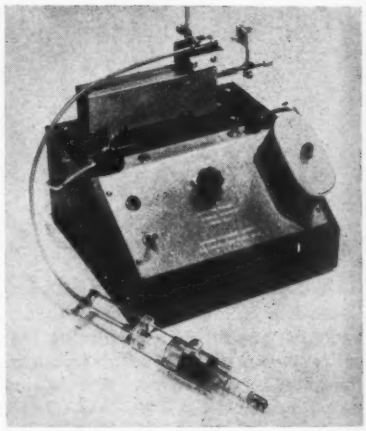


Cards on this game board stay in place regardless of motion or position. Suitable for spastics and blind persons (with braille cards), as well as patients confined to bed. Available in standard and traveler size. Gift-boxed. Neva-Bored Mfg. Co.

817. BSP liquid

New uses for BSP Liquid, originally developed for prevention and treatment of bedsores, include relief of itching and promotion of healing in chicken pox, the manufacturer says. It can be used to form a protective coating or can be effective wherever calamine is indicated. Bottles contain 4 oz. Otis E. Glidden & Co., Inc.

818. Constant flow system



Unit enables constant rate of withdrawal of blood or infusion of materials into blood stream. Lead screw driven by electronically controlled speed motor operates a standard hypodermic syringe at constant velocity, assuring uniform flow. Flow rate can be as low as 4 cc. per hour, and as high as 40 cc. per minute. Standard syringes from 5 cc. to 50 cc. capacity can be accommodated. Medical Equipment Division, Colson Corp.

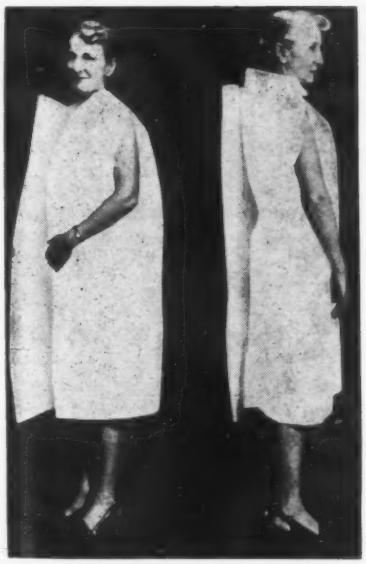
819. Aseptic swabs

Grafco Redi-Asepti Swabs, ready to use for surface antisepsis, combine cotton, gauze, and alcohol into one. Nontoxic, odorless, stainless, nonirritating, swabs are made of finely spun cotton and are saturated with 0.1% Cetylamine. Pale pink swabs, packaged in pink labeled jars, come in three sizes: 50's, 100's, and 1,000's. Graham-Field.

820. Balloon catheters

Schuco balloon catheters with Warrman safety membrane combine safety with efficiency. Tapered slot directs hypodermic needle through middle of inflation tube, facilitating puncture. Medical Products Division, Schueler & Co.

821. Disposable gowns



New full-length disposable examination gown designed for women. Can be worn to open in front or back. Made of heavy white crepe paper. Busse Hospital Products.

822. Tray diet cards

Tray diet cards, 3" sq., in bright individual colors (one for each of 14 different hospital diets, plus a plain white card), speed identification, reduce errors. Ample space for writing patient's name, room, remarks. Mealtime prayers for Catholic, Jewish, and Protestant patients are printed on the back. Colonial Hospital Supply Co.

823. Caps and masks

The "J" cap for nurses and Johnson's O.R. cap and O.R. mask are now available in misty green. Cloth is vat-dyed and sanforized. Johnson & Johnson.

824. Hospital Bingo

Specially designed for pediatric patients, Hospital-Bingo comes in eight different games with three ways to play. Cards padded with stiff backing. Child can lie in bed and play. Midwestern Publishing Co.

825. Plastic utensils

Reinforced plastic material that can be molded into various utensils for use in hospitals has excellent surface finish, is not stained by chemicals. Material can withstand steam sterilization, manufacturer says. For use in trays, bowls, basins, and other utensils requiring sterilization in hospitals. Structural Fibers, Inc.

826. Wireless buzzer

Selective signaling system signals any key individual without disturbing others. Control panel sets up signals to individual pocket receivers. Non-automatic system permits only one signal at a time, and capacity is limited to 20 receivers. Automatic system permits as many signals as capacity of the system—either 60 or 120. Auth Electric Co., Inc.

827. Bedside calling service

New locking button for hospital bedside calling service can be used with any make of cordset. Molded nylon shell provides high resistance to crushing and physical shock. Will not break when dropped or stepped on, manufacturer says. Made without use of exposed screws. Edwards Co., Inc.

828. Intercom

Newly designed master intercom has roll-in patterned steel in simulated leather and two-toned gray effect. Manufactured by Rauland-Borg Corp. for Sharon Steel Corp.

829. Pop-up viewer

Folder containing flat pop-up viewer with rotating film disc shows five miniature transparency pictures in color. Used both as mailing piece (viewer folds flat and automatically pops up on removal from envelope), and as selling tool in fund raising. Brownie Manufacturing Co.

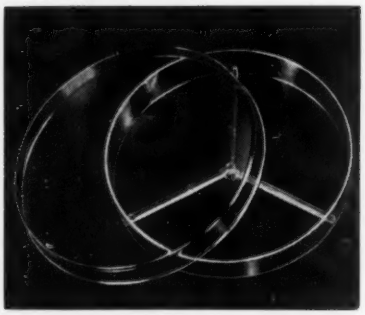
BUYER'S GUIDE

Continued

830. Whirlpool bath

Designed for efficient deep-massage hydrotherapy, Model Ete-B Whirlpool Bath can be quickly and easily installed in any bathtub. Assures equal pressure distribution and deep massage necessary for effective home hydrotherapy. Electric turbine ejector delivers 55 gal. per minute at constant velocity of 3,000 linear feet per minute. Dakon Tool & Machine Co., Inc.

831. Petri dish



Thin partitions in disposable sterile petri dish permit three separate agar beds in one plate. Each segment holds approximately 8 ml. Guarantees all external conditions to be identical. Saves media and storage space in laboratory incubator. Falcon Plastics.

832. Hemostatic product

Gelfoam, absorbable gelatin-base sponge, is a tough, non-elastic porous substance able to resist handling. May be folded or cut into any shape or size. When in contact with bleeding surface, it rapidly absorbs blood and becomes part of the clot. So adherent to bleeding surface it cannot be dislodged without tearing. After tissue organization and repair, it is absorbed without irritation. Upjohn Co.

833. Surgical stand

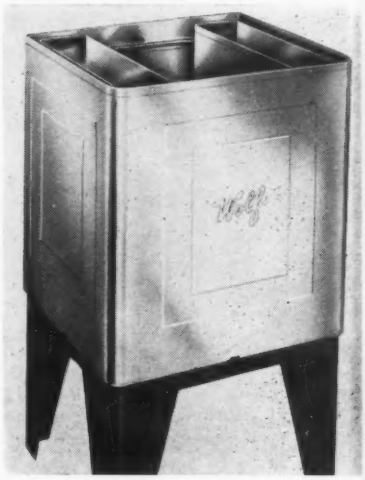
Malerich multi-purpose surgical and treatment stand replaces Mayo stands, anesthetist stands, leg and arm rests, solution stands, hypodermy supports, instrument tables, plaster and casting basin stands, suturing tables, extremity prep trays and basins. Adjustable

height makes it suitable for pediatric use. Two removable and interchangeable curved arm, leg, or head rests make possible more than 50 different combinations of positions. Wilson Mfg. Co.

834. Drainage container

Plastic urinary drainage container can be economically discarded after use on one patient. No thorough cleaning procedures and pre-assembly are required before use. Wire is attached to bed, container hung thereon, and drainage tube inserted. Container is calibrated and transparent. Can be emptied, washed, rinsed, and replaced on bed within minutes. Unpleasant odors contained with drawstrings drawn tightly around neck of drainage tube. Available in 2-liter and 4-liter sizes. Pharmaseal Laboratories.

835. Developing tank



Developing tank for x-ray film has removable inserts. Mounted on sturdy steel base with acid-resistant plumbing. Provides liberal, unimpeded wash space with outside overflow and drain. Wolf X-Ray Products, Inc.

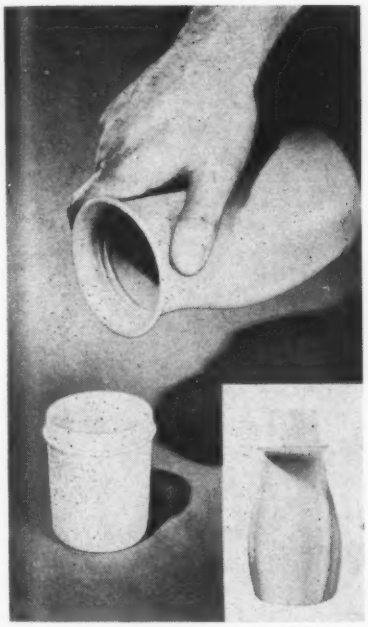
836. Pre-assembled enema

Enema disposable unit is now available with pre-lubricated rectal tube attached to polyethylene bottle, ready for use after removal of protective rectal tube cover. Diaphragm prevents leakage and controls flow. Anatomically correct tube minimizes injury hazard. C. B. Fleet Co., Inc.

837. Tubular gauze

Tubegauz, seamless tubular gauze, molds to exact shape of limb, with special applicators which make it adaptable and efficient in dressing hard-to-bandage areas. Can be applied in fraction of usual time. May be washed, sterilized, and used many times without loss of its special characteristics. Strong, yet soft, and stays in place. Scholl Mfg. Co., Inc.

838. Plastic decanter



One-piece seamless construction of plastic decanter makes it ideal for use in refrigerators or freezers. Made of lightweight unbreakable plastic. Lid serves as drinking cup. Full quart capacity. Will not rust or clatter. Available in pink or blue, with white cup-lids. American Hospital Supply Corp.

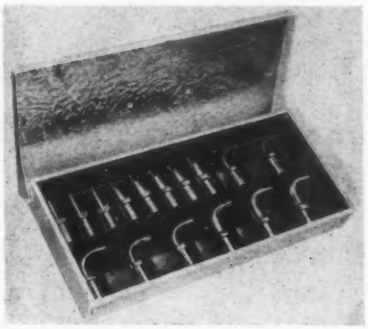
839. Bates pillow

Bates heirloom pillow has "open pores," and ability to breathe, with no trapping of stale-air cells, no lack of fresh change of air for balanced resiliency. In two sizes: family size—18¼ x 26 x 4¾"; and jumbo size—20 x 27¼ x 6¼". Bates Fabrics.

840. Infant formula

Sobee Powder, hypoallergenic soya infant formula, is companion to Sobee Liquid for infants sensitive to cow's milk. Needs to be mixed with water prior to use. Mead Johnson & Co.

841. Catheter connectors



New serrated design of 11 mm. (above) and 15 mm. catheter connectors provides excellent gripping surface. Two flat sides prevent rolling about. Minimum wall thickness allows larger airway. Aluminum case is fitted with plastic partitions to keep connectors in line and permit immediate identification of lumen size. Ohio Chemical & Surgical Equipment Co.

842. Dishwashing compound

Chlorinated machine dishwashing compound, Divoklor, simultaneously cleans and prevents staining of plastic and china dishware. Also penetrates scratched surfaces and removes deeply imbedded stains, says manufacturer. The Diversey Corp.

843. Oven

Thermo-wall oven or sterilizer occupies only 31" of bench space. Measuring 25" wide x 30" high x 19" deep inside, oven's four shelves have total loading space of 1,900 sq. in. "Space Saver" saves 40 percent space. Hot wall heat is employed, with no inside heaters in working chamber, reducing fire and explosion hazards. Labline, Inc.

844. X-ray unit

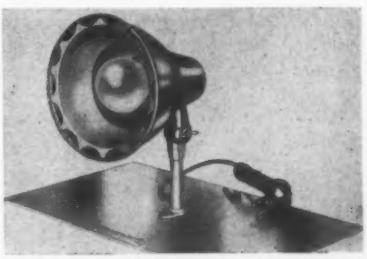
Sharper, clearer x-ray images are possible with new mobile x-ray unit featuring electronic exposure timer. Electronic circuit on Mobile "90", permitting split-second timing, greatly minimizes inconsistencies in exposures and images. Use of small (1.5 mm.) effective focal spot further enhances image detail and sharpness. Unit can be moved gently over door sills, quietly down corridors, and with ease onto elevators. General Electric Co.

845. Thromboplastin

Now available in "Dropak" package is Solu-Plastin, thromboplastin solution. Self-contained dropette, accurate as a pipette, provides drops of controlled size. Calibrated so only amount of solution necessary for individual test may be withdrawn, reducing possibility of contamination. Residual solution may be stored for future use. Each batch is individually standardized against both freshly drawn normal and dicumarolized human plasma. "Dropak" 10 ml. bottle is sufficient for 100 determinations. Schieffelin & Co.

846. Therapy lamp

Perineal therapy lamp uses "Coolshade" principle with double reflector, providing ample air space as insulation medium. Cannot tip. Rachet-type shade adjustment has three-direction variation. Uses 25-watt bulb; has 6' cord. Continental Hospital Industries, Inc.



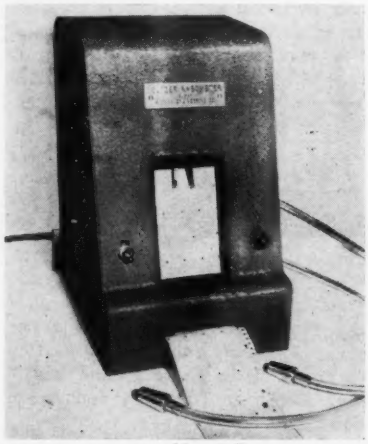
BUYER'S GUIDE

Continued

847. Albumin test

Albustix reagent strips indicate presence of albumin in urine by immediate color reaction. Intensity of color reaction is proportionate to amount of protein present. Handy color scale provided on bottle for easy identification of results and uniform recording. Strips save time, equipment, and clean-up. Ames Co., Inc.

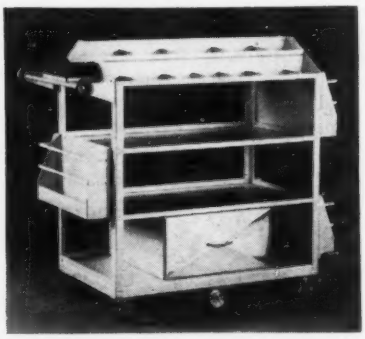
848. Seltzer Nasometer



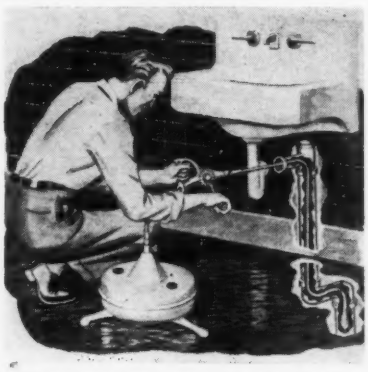
New automatic device measures degree of patency of nasal respiratory passages. Nasometer designed by Albert P. Seltzer, M.D., is actuated by patient's exhaling through each nasal passage into tubes operating Nasometer. Two pens on a single strip chart respond to flow of air end. Obstructions cause pens to produce irregular lines. Royson Engineering.

849. Hospital cart

Made entirely of durable aircraft aluminum alloy which resists denting, gift-shop cart is one-third the weight of a steel cart. Turns and handles easily on two semi-pneumatic rubber-tired wheels in center, and ball-bearing swivel casters on corners. Easy to clean. Will not absorb moisture or odors. Has lock cash box, three magazine racks, shelf dividers, donut and corner bumpers, and optional "coke" drawer. Weighs approximately 97 lbs., is 47" high, 26" wide, and 51" long. In painted or anodized aluminum. Bucks County Enterprises, Inc.

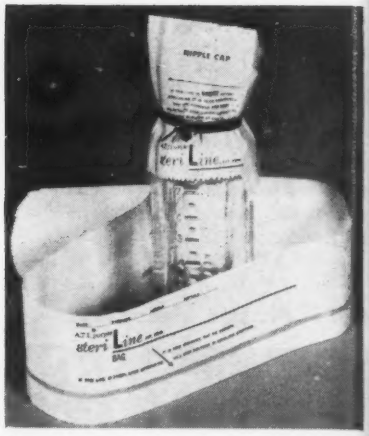


850. Drain cleaner



Miller Rod House cleans all pipelines —clogged toilets, sinks, urinals, and house-to-street sewers—up to 100 feet. Cutter blades can be added for removing roots. Patented bulb-like end makes every number of bends in pipe, manufacturer says. Miller Sewer Rod Co.

851. Indicator bags

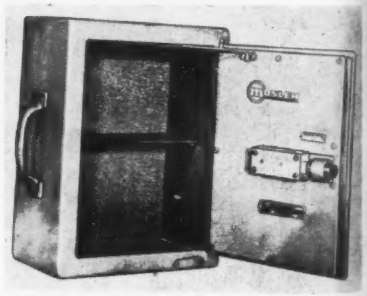


New bags—nipple cap for terminal sterilization of infant formula and a 24" bag for pipettes and extra-long catheters—each contain the same ATI "built-in" indicator which changes from purple to green when sterilization has been achieved. Aseptic Thermo Indicator Co.

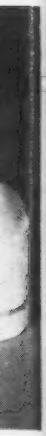
852. Shoes

Five resilient coil springs are set in sponge rubber to support foot arch and relieve legs and feet from strain. Flat foam-rubber sole. White only, in all sizes and widths. Springease Shoe Co.

853. Narcotics safe



Tamper-proof safe for storing narcotics weighs 57 lbs. Can be carried, wall-installed, or bolted down. Harold Supply Corp.



inal
nd a
-long
ATI
nges
iliza-
eptic

et in
arch
train.
only,
gease

arco-
rried,
arold

PICS

UYER'S GUIDE Information Service

Mattress pad
Glass jars
Portable cardio-encephalograph
Formula dispenser
Flame photometer
Medical isotope lab
Cancer accession register
Commode-chair
Hip exerciser
Oxygen analyzer
Gastric analysis
Testing meter
Transistorized ECG
Detergent germicide
Nonskid cartons
Syringe rack
Life-like prostheses
Bedside solitaire
BSP liquid
Constant flow system
Aseptic swabs
Balloon catheters
Disposable gowns
Tray diet cards
Caps and masks
Hospital bingo
Plastic utensils
Wireless buzzer
Bedside calling service
Intercom
Pop-up viewer
Whirlpool bath
Petri dish
Hemostatic product
Surgical stand
Drainage container
Developing tank
Pre-assembled enema
Tubular gauze
Plastic decanter
Bates pillow
Infant formula
Oven
X-ray unit
Thromboplastin
Therapy lamp
Albumin test
Seltzer Nasometer
Hospital cart
Drain cleaner
Indicator bags
Springease shoes
Narcotics safe

CONVENTION

Multi-height bed
Surgical stand
Laminectomy Rongeur
Whirlpool bath
Operating light
Private-label injectables
Power-drive wheel chair
Suction and ether unit
Field utility scissors
Petrolatum gauze
Leg splint
Anesthesia apparatus
Inform controls
Special formula pills
Frigiderm
Plastic Pak
Elastic-rubber bandage
Electrifuge
Tracheotome
Colostomy chart
Inhalator-resuscitator
Mealcart
Needle holders
O.R. table
Autoclave sterilization
Hip prosthesis
Vacutainer technic
Convertible wheel chair
Traction machine
Oxygen tent
Surgical blades
Suturing apparatus
Self-sticking labels
Foley catheter
Restraint strap
Tubal insufflator
Elastoplast

S, NEW LITERATURE

Glove chart
Vascular prostheses
Germicide folder
Gynecological instruments
O.R. equipment
Defibrillator leaflet
Laboratory glassware
Radiological motion picture recording
Electrodiagnosis instruments
Entertainment films
Postoperative care film

ERICAN PHYSICAL THERAPY OCIATION

Cane
Therapeutic furniture
Invalid walkers
One-motor whirlpool bath
Hydrocollator master units
Traction equipment
Mobile whirlpool bath
Paraffin bath
Portable traction machine
Leg bath

907C. Handicap aids
908C. Medicated powder
909C. Ultrasonic units
910C. Surgical supports
911C. Chest-abdomen respirator
912C. Motorized traction
913C. Therapeutic exercise apparatus
914C. Exercise unit
915C. Power-drive wheel chair
916C. Pressure pads
917C. Self-help device
918C. Ripple Sole shoes
919C. Precision-craft equipment
920C. Therapeutic lamps
921C. Ultrasonic technic
922C. Medco-Sonlator
924C. Inval-Aid chair
925C. Traction table
926C. Mobile patient lift
927C. Heat-therapy equipment
928C. Therapeutic books
929C. Supports
930C. Electromyograph
931C. Electro-medical equipment
932C. Multi-height bed
935C. Exerciser
936C. Portable whirlpools
937C. Ultrasonic equipment
938C. Metabolism unit
939C. Diathermy unit

FROM THE ADS—BROCHURES

940A. Aeroplast Corp., plastic surgical dressing
941A. American Cyanamid Co., Surgical Products Div., catalog
942A American Sterilizer Co. Bull. SC-312
943A. Gordon Armstrong Co., Inc. X-P baby incubator
944A. Carolina Absorbent Cotton Co., catalog, textiles
945A. Wilmot Castle Co. Castle "60 Series"
946A. Cutter Laboratories. scalp vein set
947A. Dittmar-Penn Corp., catalog, stainless steel retractors
948A. Hill-Rom Co., Inc. Procedure Manual No. 3
949A. Walter G. Legge Co., Inc. "One Little Spark"
950A. Ohio Chemical & Surgical Equipment Co., catalog

FREE SAMPLES

951A. Acme Cotton Products Co., Inc., Ray-balls
952A. A•S•R Products Corp., SteriSharps
953A. J. A. Deknatel & Son, Inc. Plastic Pak
954A. Desitin Chemical Co., ointment
955A. Kremers-Urban Co., Kutapressin
956A. Lehn & Fink Products Corp., disinfectant
957A. Massillon Rubber Co., Matex kit
958A. Meinecke & Co., Sterilwrap test kit
959A. Professional Tape Co., Inc. time labels
960A. Travenol Laboratories Inc., Incert vials
961A. Edward Weck & Co., Weck cleaner

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD

First Class Permit No. 34341, Chicago, Illinois

HOSPITAL Topics

30 West Washington Street

Chicago 2, Ill.

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD

First Class Permit No. 34341, Chicago, Illinois

HOSPITAL Topics

30 West Washington Street

Chicago 2, Ill.

BUYER'S GUIDE Information Service

800. Mattress pad
801. Glass jars
802. Portable cardio-encephalograph
803. Formula dispenser
804. Flame photometer
805. Medical isotope lab
806. Cancer accession register
806a. Commode-chair
807. Hip exerciser
808. Oxygen analyzer
809. Gastric analysis
810. Testing meter
811. Transistorized ECG
812. Detergent germicide
813. Nonskid cartons
814. Syringe rack
815. Life-like prostheses
816. Bedside solitaire
817. BSP liquid
818. Constant flow system
819. Aseptic swabs
820. Balloon catheters
821. Disposable gowns
822. Tray diet cards
823. Caps and masks
824. Hospital bingo
825. Plastic utensils
826. Wireless buzzer
827. Bedside calling service
828. Intercom
829. Pop-up viewer
830. Whirlpool bath
831. Petri dish
832. Hemostatic product
833. Surgical stand
834. Drainage container
835. Developing tank
836. Pre-assembled enema
837. Tubular gauze
838. Plastic decanter
840. Bates pillow
841. Infant formula
843. Oven
844. X-ray unit
845. Thromboplastin
846. Therapy lamp
847. Albumin test
848. Seltzer Nasometer
849. Hospital cart
850. Drain cleaner
851. Indicator bags
852. Springease shoes
853. Narcotics safe

ASTA CONVENTION

855C. Multi-height bed
856C. Surgical stand
857C. Laminectomy Rongeur
858C. Whirlpool bath
859C. Operating light
860C. Private-label injectables
861C. Power-drive wheel chair
862C. Suction and ether unit
863C. Field utility scissors
864C. Petrolatum gauze
865C. Leg splint
866C. Anesthesia apparatus
867C. Inform controls
868C. Special formula pills
869C. Frigiderm
870C. Plastic Pak
871C. Elastic-rubber bandage
872C. Electrifuge
873C. Tracheotome
874C. Colostomy chart
875C. Inhalator-resuscitator
876C. Mealcart
877C. Needle holders
878C. O.R. table
879C. Autoclave sterilization
880C. Hip prosthesis
881C. Vacutainer technic
882C. Convertible wheel chair
883C. Traction machine
884C. Oxygen tent
885C. Surgical blades
886C. Suturing apparatus
887C. Self-sticking labels
888C. Foley catheter
889C. Restraint strap
890C. Tubal insufflator
891C. Elastoplast

FILMS, NEW LITERATURE

885. Glove chart
886. Vascular prostheses
887. Germicide folder
888. Gynecological instruments
889. O.R. equipment
890. Defibrillator leaflet
891. Laboratory glassware
892. Radiological motion picture recording
893. Electrodiagnosis instruments
894. Entertainment films
895. Postoperative care film

AMERICAN PHYSICAL THERAPY ASSOCIATION

900C. Cane
900aC. Therapeutic furniture
901C. Invalid walkers
901aC. One-motor whirlpool bath
902C. Hydrocollator master units
902aC. Traction equipment
903C. Mobile whirlpool bath
904C. Paraffin bath
905C. Portable traction machine
906C. Leg bath
907C. Handicap aids
908C. Medicated powder
909C. Ultrasonic units
910C. Surgical supports
911C. Chest-abdomen respirator
912C. Motorized traction
913C. Therapeutic exercise apparatus
914C. Exercise unit
915C. Power-drive wheel chair
916C. Pressure pads
917C. Self-help device
918C. Ripple Sole shoes
919C. Precision-craft equipment
920C. Therapeutic lamps
921C. Ultrasonic technic
922C. Medco-Sonlator
924C. Inval-Aid chair
925C. Traction table
926C. Mobile patient lift
927C. Heat-therapy equipment
928C. Therapeutic books
929C. Supports
930C. Electromyograph
931C. Electro-medical equipment
932C. Multi-height bed
935C. Exerciser
936C. Portable whirlpools
937C. Ultrasonic equipment
938C. Metabolism unit
939C. Diathermy unit

FROM THE ADS—BROCHURES

940A. Aeroplast Corp., plastic surgical dressing
941A. American Cyanamid Co., Surgical Products Div., catalog
942A. American Sterilizer Co. Bull. SC-312
943A. Gordon Armstrong Co., Inc X-P baby incubator
944A. Carolina Absorbent Cotton Co., catalog, textiles
945A. Wilmot Castle Co. Castle "60 Series"
946A. Cutter Laboratories, scalp vein set
947A. Dittmar-Penn Corp., catalog, stainless steel refractors
948A. Hill-Rom Co., Inc. Procedure Manual No. 3
949A. Walter G. Legge Co., Inc. "One Little Spark"
950A. Ohio Chemical & Surgical Equipment Co., catalog

FREE SAMPLES

951A. Acme Cotton Products Co., Inc., Ray-balls
952A. A•S•R Products Corp., SteriSharps
953A. J. A. Deknatel & Son, Inc. Plastic Pak
954A. Desitin Chemical Co., ointment
955A. Kremers-Urban Co., Kutapressin
956A. Lehn & Fink Products Corp., disinfectant
957A. Massillon Rubber Co., Matex kit
958A. Meinecke & Co., Sterilwrap test kit
959A. Professional Tape Co., Inc. time labels
960A. Travenol Laboratories Inc., Incert vials
961A. Edward Weck & Co., Weck cleaner

800.	814.	829.	844.	860C.	875C.	890C.	901C.	914C.	930C.	947A.
801.	815.	830.	845.	861C.	876C.	891C.	901aC.	915C.	931C.	948A.
802.	816.	831.	846.	862C.	877C.	885.	902C.	916C.	932C.	949A.
803.	817.	832.	847.	863C.	878C.	886.	902aC.	917C.	935C.	950A.
804.	818.	833.	848.	864C.	879C.	887.	903C.	918C.	936C.	951A.
805.	819.	834.	849.	865C.	880C.	888.	904C.	919C.	937C.	952A.
806.	820.	835.	850.	866C.	881C.	889.	905C.	920C.	938C.	953A.
806a.	821.	836.	851.	867C.	882C.	890.	906C.	921C.	939C.	954A.
807.	822.	837.	852.	868C.	883C.	891.	907C.	922C.	940A.	955A.
808.	823.	838.	853.	869C.	884C.	892.	908C.	924C.	941A.	956A.
809.	824.	839.	855C.	870C.	885C.	893.	909C.	925C.	942A.	957A.
810.	825.	840.	856C.	871C.	886C.	894.	910C.	926C.	943A.	958A.
811.	826.	841.	857C.	872C.	887C.	895.	911C.	927C.	944A.	959A.
812.	827.	842.	858C.	873C.	888C.	900C.	912C.	928C.	945A.	960A.
813.	828.	843.	859C.	874C.	889C.	900aC.	913C.	929C.	946A.	961A.

Send more information on items circled. OCTOBER 1957.

Name ..... **Position** .....
(Please Print)

Hospital .....

Address .....

City ..... **Zone** ..... **State** .....

800.	814.	829.	844.	860C.	875C.	890C.	901C.	914C.	930C.	947A.
801.	815.	830.	845.	861C.	876C.	891C.	901aC.	915C.	931C.	948A.
802.	816.	831.	846.	862C.	877C.	885.	902C.	916C.	932C.	949A.
803.	817.	832.	847.	863C.	878C.	886.	902aC.	917C.	935C.	950A.
804.	818.	833.	848.	864C.	879C.	887.	903C.	918C.	936C.	951A.
805.	819.	834.	849.	865C.	880C.	888.	904C.	919C.	937C.	952A.
806.	820.	835.	850.	866C.	881C.	889.	905C.	920C.	938C.	953A.
806a.	821.	836.	851.	867C.	882C.	890.	906C.	921C.	939C.	954A.
807.	822.	837.	852.	868C.	883C.	891.	907C.	922C.	940A.	955A.
808.	823.	838.	853.	869C.	884C.	892.	908C.	924C.	941A.	956A.
809.	824.	839.	855C.	870C.	885C.	893.	909C.	925C.	942A.	957A.
810.	825.	840.	856C.	871C.	886C.	894.	910C.	926C.	943A.	958A.
811.	826.	841.	857C.	872C.	887C.	895.	911C.	927C.	944A.	959A.
812.	827.	842.	858C.	873C.	888C.	900C.	912C.	928C.	945A.	960A.
813.	828.	843.	859C.	874C.	889C.	900aC.	913C.	929C.	946A.	961A.

Send more information on items circled. OCTOBER 1957.

Name ..... **Position** .....
(Please Print)

Hospital .....

Address .....

City ..... **Zone** ..... **State** .....

FILMS AND NEW LITERATURE

885. Glove chart

Wall chart to help hospital workers stretch the life of surgeons' gloves covers all phases, from washing to sterilization and storing, in nine essential steps. Wilson Rubber Co.

886. Vascular prostheses

Ethi-Graft vascular prostheses woven of Mersilene polyester fiber are described in 16-page booklet. Large line drawings demonstrate method of use. Ethicon, Inc.

887. Germicide folder

San Pheno X, a safe, non-specific germicide, can be used throughout hospital on floors, walls, furniture, and equipment, according to new folder. Is nonirritating and nonsensitizing. Huntington Laboratories.

888. Gynecological instruments

Gynecological specialties pictured and described in leaflet include Weisman-Graves vaginal speculum, new leakproof tubal insufflation cannula, nontearing tenaculum forceps, and improved malleable biopsy curette with speared point. The Lawton Co.

889. O.R. equipment

Many redesigned pieces of stainless steel operating room equipment are featured in new folder. Items include Mayo stand, kick bucket, instrument table, irrigator stand, foot-stool, revolving stools, solution stand, sponge rack, utility table, and dressing carriage. S. Blickman, Inc.

890. Defibrillator leaflet

Leaflet describes Morris external-internal defibrillator, indicating applicability for closed- and open-chest cardiac resuscitation. Included is information on technic, development of external defibrillation, features and engineering specifications, and a bibliography. Levinthal Electronic Products, Inc.

891. Laboratory glassware

Laboratory glassware and clinical supplies catalog lists over 200 items, each illustrated and completely identified for easy reference. Glasco Products Co.

892. Radiological motion-picture recording

New film method of recording fluoroscopic examination study includes schematic drawing of principles of operation. Photographs demonstrate that unit can be used for all diagnostic applications and does not interfere with normal fluoroscopic work habits. Westinghouse Electric Corp.

893. Electrodiagnosis instruments

Instruments for electrodiagnosis and electrotherapy are described in leaflet. Models include electromyographs and stimulators. The Meditron Co.

894. Entertainment films

More than 600 16 mm. entertainment films available to nontheatrical exhibitors are listed in new catalog. 16 mm. Cinemascope versions in color of many of the latest films are also available. United World Films.

895. Postoperative care film

"Immediate Postoperative Care," a 25-minute, full-color film, shows wide variety of procedures, equipment, drugs, and special skills. Film begins with technics applying to all patients, then shows portions of different surgical procedures. Squibb, Division of Olin Mathieson Chemical Corp.

So they may see...

Famous Castle illumination is now combined with the most maneuverable major surgical lamps ever built.

Without use of tracks or counterweights, Castle "60 Series" Lights provide new feathertouch mobility... permit instant control of light *by the surgical team.*

Fine adjustments are made in seconds... light beamed instantly where it is needed by those who actually see the result in the incision.

The result is proper and quicker light placement... faster, clearer, fatigue-free vision... better surgery.

Write for folder on Castle "60 Series" Lights and Color Camera Attachment.

Castle

WILMOT CASTLE COMPANY
17031 East Henrietta Road • Rochester, N. Y.
LIGHTS AND STERILIZERS

American Surgical Members View

Shown on these and the next six pages are some of the newest products displayed at the recent ASTA convention in Chicago.

Top to bottom:

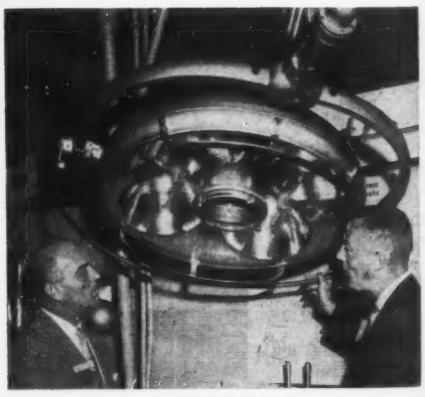
Don W. Iams (r.), Feick Brothers Co., listens to William Friedlander, Inland Bed Co., explain how the counter-balanced, single-action, multi-height bed (No. 873) can be raised with minimum effort. Walter F. Smith (l.), Inland, looks on. 855C.

Newest Wilson Mfg. Co. product displayed was the Malerich multi-purpose surgical and treatment stand capable of 50 positioning combinations. L. to r.: John J. McGuire, Colonial Hospital Supply Co., John H. Lacy, Maine Surgical Supply Co., listen to Mike Chalverus, Wilson. 856C.

Examining a 9½" side-curved Lesksell double-action laminectomy Rongeur is Louis Holstein (r.), Seiler Surgical Co., Inc. James Thoma, Ohio Chemical and Surgical Equipment Co., explains its features. 857C.

Left: "Kickapoo" Logan (center) demonstrates the Logan Whirlpool Bath for William George Stenhouse (l.) and Bill McGourin (r.), both of Doctors & Hospital Supply. 858C.

Right: Direct light control by the surgical team is possible with the sterile handles on Castle No. 62 major operating light. D. B. Yauger, Peacock Surgical Co., Inc., listens with interest to John Gabel, Wilmot Castle Co. 859C.



Trade Association New Items

For more detailed information on any product pictured, circle the appropriate number on the Buyer's Guide card opposite page 72.

Top to bottom:

Alex MacKinnon (l.), Rupp and Bowman Co., chats with Aaron Barry at the Barry Laboratories, Inc. booth. On display were the private-label injectables, which include custom designing of the package, and allergy diagnostic materials. 860C.

Dan Kelley, Everest & Jennings, shows the power-drive wheel chair with its single-button control to Charles Kratt (l.), Scully-Walton, Inc., and Clarence Smith, Everest & Jennings. 861C.

New features of the stand-mounted suction and ether unit No. 900, including ether system with micrometer-type regulator and aerovent overflow protection, is pointed out by Thomas S. Hoffman (l.), Gomco Surgical Mfg. Co., to Fred Capace, John McGuire, Jr., and Matthew Miller (l. to r.), all of Colonial Hospital Supply Co. 862C.

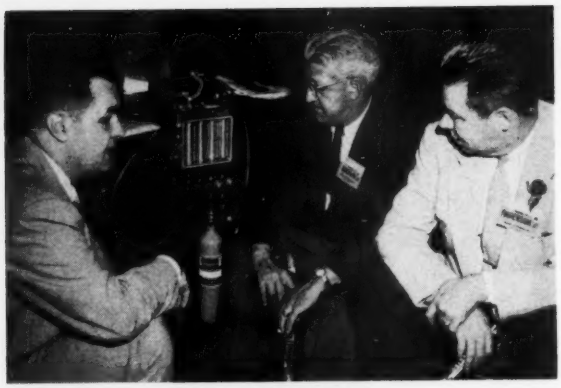
(For additional news of the meeting see pages 20 and 21)

Showing a pair of field utility scissors to E. F. Erbacher, Schuemann-Jones Co., is Ludwig Wittener (l.), vice-president, Kny-Scheerer Corp. 863C.

Left: Ray Thompson (r.), Shaw Surgical Co., chats with Stanley Kalish, Chesebrough-Pond's, Inc. On display is the Vaseline Sterile Petrolatum Gauze U.S.P. in foil envelope and plastic tube. 864C.

ASTA Product Parade

(Continued)



E & J MFG. CO.

At left, top to bottom:

Jack Williams, Jr., E & J Mfg. Co., discusses E & J anesthesia apparatus with Charles T. Brown, Jr. and Robert E. Anderson, Jr. (l. to r.), both of Powers & Anderson, Inc. E & J Series 25 is portable, simple and convenient. Accessory bases available for permanent operating room use. 866C.

SMITH & UNDERWOOD

Kay Surgical, Inc. salesmen Van Oliver (l.) and A. R. Sehnert (center) learn about improvements on Diack and Inform controls from Robert F. Smith, Smith & Underwood. 867C.

LAFAYETTE PHARMACAL, INC.

Harold Roberts (l.), Crocker-Fels Co., hears about special formula pills from C. W. Griggs, promotion manager, and Emily Bryan, both of Lafayette Pharmacal, Inc. 868C.

BRACHVOGEL-HOVEY

Fred B. Hovey, Jr., Brachvogel-Hovey, demonstrates the use of the skin refrigerant-anesthetic, Frigiderm, to (l. to r.) Mrs. Tom B. Slade, Jr., Surgical Supply Co., Mrs. Mack Fullton, Winchester-Ritch, and Mrs. Dick Roda, Taylor Instrument Co.'s Frigiderm is said to offer faster topical freezing action and to provide a bloodless field during skin planing. 869C.

ORTHOPEDIC FRAME CO.

Above:

L. W. Jordan and Mrs. Jordan, Radebaugh-Fetzer Co., examine adult leg splint on model Janice Newton while Ronald Carson, Orthopedic Frame Co., demonstrates how the ankle traction cuff is equipped. Three web straps, tightened snugly, provide moderate, uniform compression. 865C.

J. A. DEKNATEL & SON, INC.

Top to bottom:

The Deknatel Plastic Pak, featured at the Deknatel booth, has a safety seal which guarantees against leakage. Shown above (l. to r.) are J. B. Dixon, Melton Co., Inc., Tom J. Mackey, Karel First Aid Supply Co., and Francis T. Glynn, Deknatel. 870C.

MEDICAL FABRICS CO., INC.

Flex-Master, the elastic-rubber hospital bandage that withstands washing and repeated hospital usage, holds the attention of Guy Moore and Clifford L. Roberts, Melton Co., Inc., as Jack Coates, Medical Fabrics Co., explains. 871C.

Electric brake and safety switch in the C.S.E. electrifuge are pointed out by Steve J. Nagy, Chicago Surgical & Electrical Co., to Paul J. Tuckett (l.) and A. Lynn Jensen (r.), both of Physicians' Supply Co. 872C.

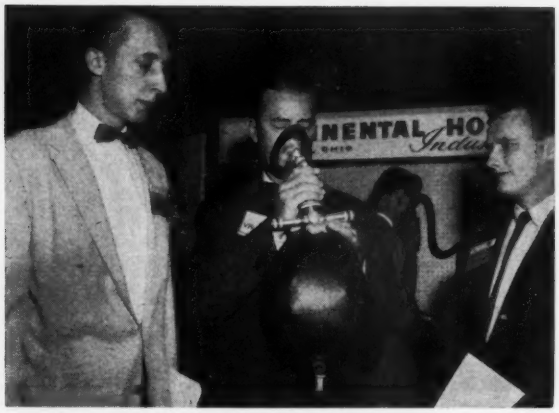
CHICAGO SURGICAL & ELECTRICAL CO.

Emergency tracheotomy technic with the Sierra-Shelden tracheotome is explained by Mrs. Edith H. Fish, Sierra, to Lee Rammel (second from l.), Massey Surgical, Inc. salesman, while Steve Puleo, Massey, and Lou Juergens, Sierra, look on. 873C.

Below: United Surgical's Jack Blackwood (r.) explains the colostomy chart to Al Evans, Earl Netwal, and Bernard Parker (from l.), of Brown & Day. 874C.

UNITED SURGICAL SUPPLY CO.

SIERRA ENGINEERING CO.



A pocket-size inhalator-resuscitator using thumb-sized replaceable oxygen cylinders is demonstrated by Jim Valentine, Continental Hospital Industries, Inc., to Gil Miller (l.) and David Jacobs, both of Schuemann-Jones Co. Six liters of oxygen can be released into rebreathing bag in seconds, by twists of wrist. 875C.

C. G. Sanderson, Ritter Co., operates hand lever to demonstrate one of 12 basic positions possible in the Ritter Universal Table to (l. to r.) Cyrus B. Brown, Jr., Brown and Day, Inc., Paul Hanafin, Ritter, and Jack Spellacy, Brown & Day. 878C.

The Shampaine Super-Mealcart, double-walled, fully insulated, with mechanical refrigeration, compact heated drawers, removable beverage bar, and oven compartment, attracts the attention of Leonard Fript, Mills Hospital Supply Co., and H. S. Goff, J. D. Graham, and Eddie Smucygz (l. to r.), all of Medical Supply Co. 876C.

George Landman (l.), vice-president in charge of sales, Pelton and Crane Co., answers questions from South Jersey Surgical Supply Co. representatives (l. to r.) Wallace Waldman, Raymond Goldstein, and Morton Winer, on autoclave sterilization. All models are self-contained, storing steam under pressure available for immediate use as long as switch is turned on. 879C.

Goetz-Niemer Co. representatives Jim Hinckley, Charles Acker, H. H. Goetz, Jr., and Glenn Ford (from l.) examine the Sklar needle holders with T-C jaws, while Bob Saunders (second from r.), J. Sklar Mfg. Co., answers their questions. Handles are copper-plated for easy identification. 877C.

R. T. Wilson, Jr. (l.), Wilson X-Ray and Surgical Co., examines the Wilson Wedge prosthesis for hip joint, femur and acetabulum combination, held by James Gary, Orthopedic Equipment Co. Gus Dimberg (second from l.) explains. Looking on are Gil Frommelt and Bill Strybel (l. to r.), also of Orthopedic Equipment Co. 880C.

George Gessner, Becton, Dickinson and Co., explains the B-D Vacutainer technic for collection of blood specimens to S. F. Saraga (l.), Radebaugh-Fetzer Co. At right is Frank Selmser, Becton-Dickinson. Also featured was the new sterile disposable blood lancet which produces a gape incision that avoids premature closure and clotting, and provides adequate blood flow without "milking." 881C.

Top, right: Bruce Barber (l.) and Edward V. Barber, Gendron Wheel Co., watch William Courtney Wayne, Pharmacal Supply Co., Inc., try the electric wheel chair with detachable battery and controls. Wheel chair can be converted into a parkside chair or a conventional chair. 882C.

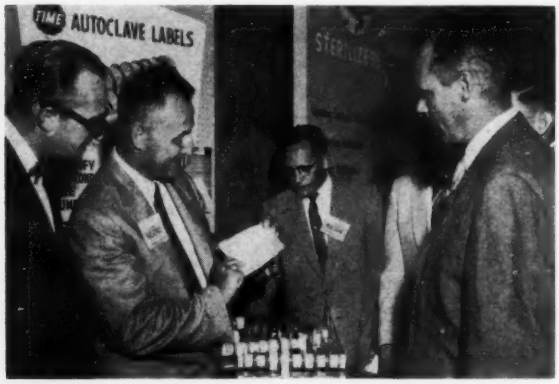
Right: Tru G. Wilhelm (r.) demonstrates the new tractomatic, portable intermittent traction machine to David Meadows, Physicians and Hospital Supply Co. It can be used for horizontal or vertical cervical traction or pelvic traction. Features are easily adjustable. 883C.

Schuemann-Jones Co. representatives Clement A. Beargie, A. S. Zeleznik, and Edwin Erbacher (l. to r.) get information from Russell Ladd (r.), McKesson Appliances, about the new Aqualor Hi Humidity oxygen tent. In the background is W. C. Kellogg, vice-president, McKesson. Tent's features include a separate oxygen flowmeter, accessibility of the nebulizer nozzle, ease of cleaning, and solution that condenses and can be reused without waste. 884C.

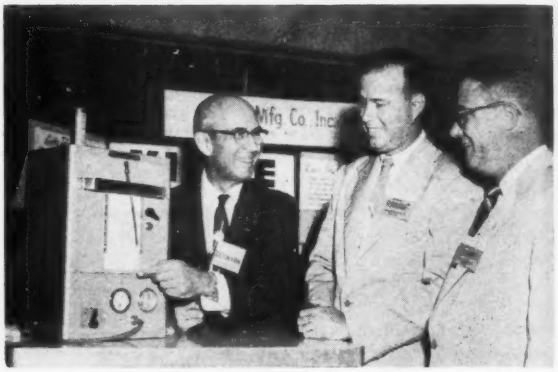
William Moore (l.), Jeffrey-Fell Co., chats with James Hurley, A•S•R Products Corp., about SteriSharps, sterile stainless steel surgical blades. 885C.

Above: The Von Petz suturing apparatus, an improved stomach and intestinal suturing instrument, is displayed by Ted Sifo (r.), Dittmar-Penn Surgical Instrument Co., to John J. Stephens (center), Rickrich Surgical Supply Co., while Paul W. Girard, Dittmar, looks on. 886C.

Below: John Nerad, Professional Tape Co., Inc., shows one of the company's vinyl-coated self-sticking labels which can stand reautoclaving five times to John Kunerth, Keith Brown, John Vander Waal (partly hidden), Bill Pochardt (not seen), and Dan Darroch (l. to r.), all of Kreiser Surgical, Inc. 887C.



The Bardex Foley catheter with specially designed diaphragm plug is explained by Hal Holcroft (r.), C. R. Bard, Inc. L. to r.: Howard Doerr and David Larsen, Bard, Kenneth Grimes, Randolph Surgical Supply Co., Melvin Waltz, Wayne Pharmacal Supply Co., Inc., and A. Theodore Schuessler, Jr., Bard. Catheter is easily inserted and withdrawn. Reinforcing ribs in the balloon assure even distention. 888C.



Top picture: Davol Rubber Co.'s Hal Chester (r.) shows S. J. Roberts, R. L. Scherer Co., a restraint strap equipped with special buckles for easy attachment to the operating table at side rails. Also on display at the booth were a new line of transparent endotracheal tubes and inflatable cuffs, unbreakable tubing connectors, and other conductive rubber accessories. 889C.

Above: Kent Costikyan (l.), Kidde Mfg. Co., explains how gravity gasometer in the Kymograph Model No. 605850, a Kidde tubal insufflator, limits pressure to safe maximum of 200 mm. Hg. Observers are Benjamin E. Ragan and George Duffy (l. to r.), both of Surgical Equipment Co. 890C.

Eugene Beck, Duke Laboratories, Inc., tells B. A. Kozlowski (r.), Karel First Aid Supply Co., about Elastoplast, the stretchable, adhesive-surfaced bandage and unit dressing. The Duke booth also displayed Gelocast, an Unna paste bandage. 891C.

Top picture: The Austin Moore Vitallium self-locking hip prosthesis is shown by John H. Begert, Austenal, Inc., to Bob McAuliffe (center) and Charles Kelley (r.), Crowley and Gardner Co. salesmen. Prosthesis is easy to insert, withstands stress of active use. Made of noncorrosive Vitallium. Head is light, strong and highly polished for articulation. 892C.

Bottom picture: Tom Brown (l.), Bauer & Black, shows a package of sheer 51-gauge nylon elastic stockings to James Kyle, Surgical Equipment Co. Also featured at the booth was the Curity suture and ligating reel ready for use as it comes from the packet. 893C.

Above: E. Savage (center), American Cystoscope Makers, Inc., discusses the ACMI latex inflatable retention catheter with Vern Copley (l.) and Ted Miller (r.), Joseph E. Dahl Co. Catheter is durably made to withstand boiling and autoclaving. 894C.

Above: Allan Hudson (l.), Hudson Oxygen Therapy Sales Co., explains features of the Hi Humidity Croup tent to Melton-Myers, Inc. representatives Roy W. Cody and Clifford Roberts (from l.). C. H. Hudson, M.D. (r.), Hudson, looks on. 895C.

Below: Explaining advantages of the cuticular needle holder and scissors combination to Henry Pekala (l.) and Tony Patti (r.), Rupp and Bowman Co., is Ed Hilgers, Ethicon, Inc. Rounded jaw edges prevent suture snagging. Beveled edges insure firm grip on needles and contour feature lessens "hand fatigue." 896C.

Above: T. Emmet Anderson, Jr., Sam P. Bowles, and Guy E. Cuthbert (l. to r.), all of Anderson Surgical Supply Co., learn about the Adams Micro-Hematocrit centrifuge from Lou Biery (second from r.), Clay-Adams, Inc. Centrifuge is safe, noiseless, operates at 12,000 RPM, and takes only three minutes for test. It stops fast and has interchangeable heads. 897C.

Therapists View Aids for Handicapped

Described on this and the following two pages are exhibits from the recent annual American Physical Therapy Association meeting. For further information on any of the products, please circle the Buyer's Guide number on the card opposite page 72.

Above: Emmett Brown, Rehabilitation Products (Division of American Hospital Supply Corp.), shows Tomac "Ankle-Action" Tripod cane to a delegate. 900C.

Items in the American Hospital Equipment Service booth included Resista-Skid invalid walkers for adults and children, and Resista-Skid safety rails for tubs and showers. 901C.

Custom-built therapeutic furniture, both beautiful and functional, was displayed by Jay L. Warren, Inc. 900aC.

Demonstration of "one motor" mobile whirlpool bath was featured by Whitehall Electro Medical Co., Inc. Equipped with turbine assembly that functions as both agitator and emptying device. Special plumbing not necessary for installation. 901aC

Zimmer Mfg. Co. demonstrated various equipment for use in traction, including Hausted Tractionaid, for use in cervical and pelvic traction. 902aC.

Above: On right-hand side of aisle, reading from back, were Chattanooga Pharmacal Co., Inc.; Ille Electric Corp.; Thermo-Electric Co., and Tru-Eze Mfg. Co., Inc. Demonstrated at the Chattanooga booth were all current models of Hydrocollator master units. 902C.

Ille showed a mobile whirlpool bath with mobile adjustable high chair and paraffin bath, and demonstrated how the care of infantile paralysis, arthritis, and other disabling conditions can be improved by the use of Hydromassage Subaqua therapy tanks. 903C.

Dickson paraffin baths were displayed by the Thermo-Electric Co. Features include mahogany mouldings designed for comfort of patient, double control of the melting element insuring maximum safety, and an improved patented drain. 904C.

Tru-Eze Mfg. Co. demonstrated the new Tractomatic, portable intermittent traction machine, adaptable to horizontal cervical or pelvic traction, or vertical cervical traction. Simple to operate, easy to adjust. 905C.

Paust muscle stimulators, for general stimulation therapy, and with galvanic current for denervation, ion transfer, and diagnosis, were featured by Physical Medicine Products Co. 905aC.

Fred Heiseman, S. Blickman, Inc., tells two delegates about stainless steel leg bath. Available are Radcliffe Model leg bath with turbine injection, and Braddock Model contrast leg bath. 906C.

At right: J. J. Block (r.) tells about his aids for the handicapped. Items include parallel bars, built-up velocipede, stand-up table, adjustable box glider, and an all-adjustable posture chair. 907C.

Bristol-Myers Products Division featured Ammens medicated powder, a starch-base preparation recommended for use under braces and casts. 908C.

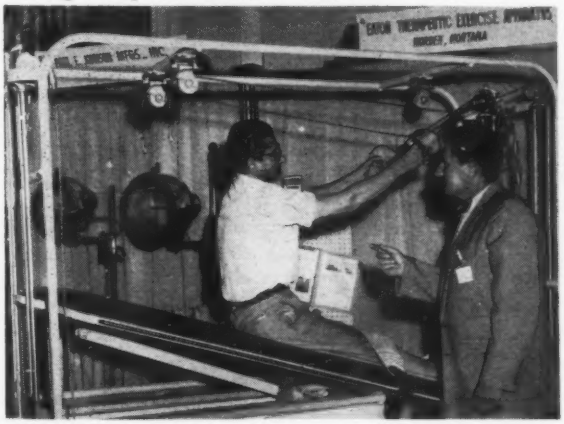
Items on display at the Burdick Corp. booth were UT-1 and UT-4 ultrasonic units, both microwave and conventional short-wave diathermy and electrical stimulating equipment. 909C.

S. H. Camp & Co. featured new developments in surgical supports and appliances, designed for comfort and quality. 910C.

Left: Model demonstrates Technicon-Huxley chest-abdomen respirator which makes it possible to employ combinations of cuirass and positive pressure, or abdominal belt and positive pressure. Conitech, Ltd. 911C.

DePuy Mfg. Co. displayed Nectrac, motorized intermittent traction which is simple yet effective, according to manufacturer. 912C.

Below: Tom Eaton (r.), Eaton Therapeutic Exercise Apparatus, explains how apparatus combines mobility, tilting table-bed, and pulley weights, enabling better functional positioning. Minimizes physical effort in administering therapeutic exercises. 913C.



With Elgin exercise unit, displayed by Elgin Exercise Appliance Co., simple functional exercises and the most highly definitive focal exercises may be performed, with both surgical and nonsurgical patients. 914C.

Main feature of the Everest & Jennings booth was the new power-drive wheel chair, with single push-button control. 915C.

Alternating pressure point pad units for cases of long confinement, especially when turning patient is not advisable, were shown by the R. D. Grant Co., which says pads have been proved clinically helpful in 89 percent of cases of threatened or existing decubitus ulcers. 916C.

Emma Coleman (second from r.), Fascole Shopping Center for the Disabled, points out one of line of self-help devices. 917C.

Ripple Sole® shoes were available for trying on at the Hack Shoe Co. booth. Also exhibited were pigeon-toe, clubfoot, and surgical shoes, and convalescent boots. 918C.

Left: W. R. Hausmann Woodwork, Inc., had on exhibit its line of precision-crafted equipment. In addition to standard equipment, Hausmann custom-builds equipment from customers' blueprints. 919C.

Paul E. Johnson Mfrs., Inc., offers therapeutic lamps from 450 to 1450 watts. Features include heavy bases on easy-rolling casters, Safety-Clutch-Lock arms, and Glolite luminous-infrared ray generators. 920C.

R. J. Lindquist Mfg. Co. demonstrated stationary ultrasonic technics, for use when constant attention of therapist is not required. Large area multiple-crystal soundheads for improved therapeutic results. 921C.

Highlight of Medco Products Co. booth was the Medco-Sonlator, combining muscle stimulation and ultra-sound simultaneously through single three-way sound applicator. 922C.

Therapists View Aids For Handicapped

Paul Jones (center), Hausted Mfg. Co., operates Inval-Aid chair with Pat Riley, Denver, in chair. 924C.

Sturdily constructed Porto-Lift for patient transfer is completely mobile, utilizing easy-to-operate hydraulic action, eliminating physical strain on attendant. 926C.

Ries' Moistaire heat-therapy equipment gives safe, comfortable, and effective moist heat at desired treatment temperature. 927C.

Left: Delegate obligingly poses on Hill Laboratories' traction table for steady or intermittent traction, for cervical, thoracic, lumbar, and lower extremity. 925C.

New books displayed by W. B. Saunders Co. were *Therapeutic Exercise* and *Muscle Testing*. 928C.

Spencer supports are individually designed for men, women, or children, to assist in their rehabilitation. Spencer, Inc. 929C.

Visitors to Teca Corp. booth operated the new electromyograph with features that simplify the recording of accurate EMG's. 930C.

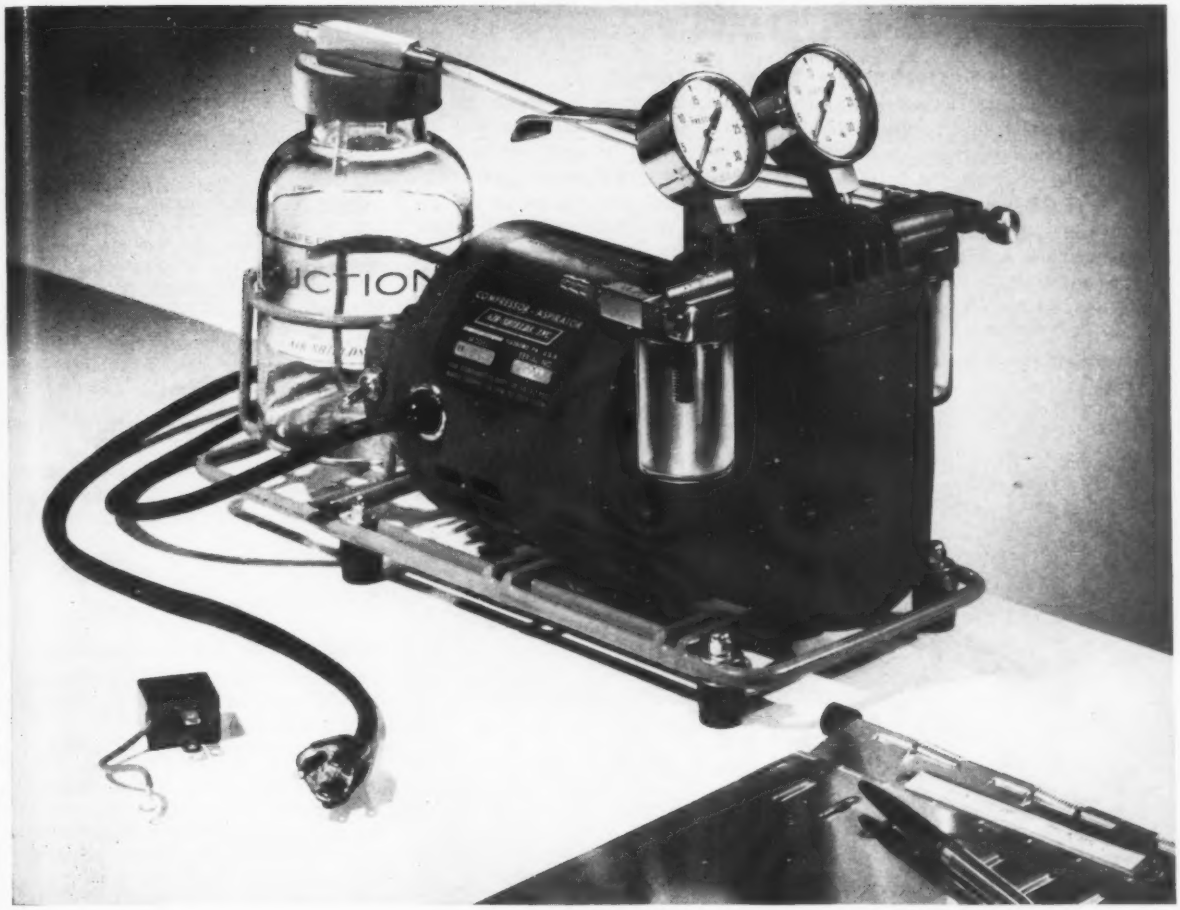
Below: J. A. Preston Corp. showed exercise apparatus, electro-medical equipment, self-help devices, cerebral palsy aids, special crutches, canes, walkers, diagnostic apparatus, books, and special equipment for home care. 931C.

John Plesko (l.), Power Products Corp., tells Charles Mehalko, Oakwood Hospital, Dearborn, Mich., about multi-height bed, while Sister Mary Peter, St. Francis Hospital, Hartford, Conn., looks on. 932C.

Shown above are Logan, Inc.; LaBerne Mfg. Co., and the Birtcher Corp. LaBerne featured a new portable progressive resistance and assistive exerciser that conditions musculature, aids joint motion and circulation. Permits knee and hip flexion, pelvic stabilization, and exercises of trunk muscles. 935C. Logan displayed two models of portable whirlpools—clinical, and arm and leg. 936C. Birtcher showed its line of ultrasonic equipment. 937C.

New at Liebel-Flarsheim Co.'s booth was the BasalMeteR, automatic self-calculating metabolism unit. 938C.

Exhibited in the Raytheon Mfg. Co. booth was the Microtherm Microwave diathermy unit and the ultrasonic therapy unit. 939C.



New portable compressor-aspirator unconditionally guaranteed for 1 year!

The new AIR-SHIELDS DIA-PUMP* is designed for continuous operation wherever regulated suction or oil-free compressed air is needed. Portable, rugged, quiet, and virtually trouble-free, the DIA-PUMP has been test-run continuously, day and night, for an entire year without failure of any part, and is unconditionally guaranteed for 1 year. This compact, new diaphragm-type compressor-aspirator cannot rust, "freeze" or jam from condensed or aspirated moisture, provides filtered, *oil-free* air at controlled pressures up to 30 pounds, or controlled suction up to 23 inches of mercury. *Standard model:* 1/6 HP motor, 115 volt, 60 cycle A.C., with ground wire and adapter plug for 2 and 3-pronged outlets. Special models available for use with other currents. Write us for special DIA-PUMP folder, or phone collect from any point in the U.S. AIR-SHIELDS, INC., Hatboro, Pa. (OSborne 5-5200).

Dia-Pump*

The new portable compressor-aspirator by **AIR-SHIELDS, INC.**

*Trademark

prescription pad

Lowering Blood Cholesterol

Linodoxine emulsion, a new product of Pfizer Laboratories, is designed to bring down elevated cholesterol levels by providing an improved balance of unsaturated (essential) fatty acids.

Each tablespoonful (15 cc.) contains 4.5 gm. linoleic acid and 5 mg. pyridoxine hydrochloride. Caloric content is 210 calories per 45 cc. (the recommended daily dosage).

Linodoxine is supplied in pint bottles.

Liquid Antacid

The antacid Trisogel (magnesium trisilicate and colloidal aluminum hydroxide, Lilly) is now available in liquid form as well as in pulvules.

Liquid Trisogel, suggested for the treatment of peptic ulcer and gastric hyperacidity, is a mint-flavored aqueous suspension. It is supplied in 12-oz. bottles.

Allergy Relief

Lontabs, the antihistamine tablets recently introduced by Ciba, have a new type of coating which provides a prompt release of Pyribenzamine and a core with Pyribenzamine particles which are slowly and uniformly dissolved.

According to the manufacturer, the tablets provide more consistent relief than "repeat" action tablets which release drugs intermittently.

The outer Rotocote shell is said to disintegrate in about 10 minutes.

Vitamins for Children

Zymbasic drops, a multi-vitamin formula for pediatric use, has been released by The Upjohn Co.

Average dosage suggested for infants and children is 0.6 cc. daily, which provides 500 units of vitamin A, 1,000 units vitamin D, 50 mg. vitamin C, and 1 mg. vitamin B_6.

Zymbasic drops are packaged in bottles of 15, 30, and 50 cc. with a calibrated dropper.

Treatment of Trichomoniasis

Tritheon tablets are given orally for treatment of trichomoniasis in the male and female.

Each tablet contains 100 mg. of 2-acetyl-amino-5-nitrothiazole (aminitrozole). Usual dosage is one tablet, three times daily, for 10 days. Tritheon is manufactured by the Ortho Pharmaceutical Corp.

Oral Anticoagulant

Sintrom (acenocoumarin), an oral anticoagulant of high potency, has been introduced by Geigy Pharmaceuticals.

Hypoprothrombinemia is said to be rapidly achieved with a minimal dosage. Therapeutic level is reached within 36 to 48 hours, according to clinical experience. Because of drug's intermediate action, hypoprothrombinemia can be readily reversed within 24 to 48 hours on cessation of therapy.

Sintrom is supplied in bottles of 50 double scored 4 mg. tablets.

Antiallergic-Antipruritic

Sandostene Spacetabs are 75 mg. prolonged-action tablets of Sandostene (methyl - amino - phenyl - thenyl - piperidine tartrate, an antiallergic-antipruritic combining inhibition of blood-vessel permeability, anticholinergic action, and histaminic antagonism.

According to the manufacturer (Sandoz Pharmaceuticals), the product provides maximum relief of hay fever, allergic rhinitis, and itching associated with various skin conditions.

Spacetabs come in bottles of 100.

VASELINE® PETROLATUM GAUZE

conforms fully to the official standards prescribed by the U.S.P.

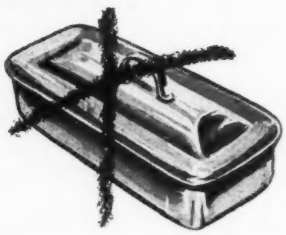
This prepacked, pretested material assures unquestionable sterility at time of use.

Especially-designed equipment impregnates the gauze so lightly and uniformly that the danger of maceration is minimized.

Most hospitals are neither staffed nor equipped to follow the U.S.P. XV specifications for the preparation and control testing of a dependably sterile petrolatum gauze. That is why 'Vaseline' Sterile Petrolatum Gauze U.S.P. is their choice of a nonadherent dressing. It has proved itself "best by test" in millions of cases in thousands of civilian as well as military hospitals throughout the United States.

WHY USE SUBSTANDARD MATERIAL

when this superior prepacked sterile product is available at a worthwhile saving?



CHESEBROUGH-POND'S INC.
Professional Products Division
NEW YORK 17, N.Y.

VASELINE is a registered trademark of Chesebrough-Pond's Inc.

Heparin in Saline

Abbott Laboratories is now offering heparin in saline in a 500-cc. siliconed blood recipient bottle, with a 43-mm. flanged rubber closure.

Each bottle contains 30 cc. isotonic saline and 15 mg. heparin sodium, 1500 U.S.P. units, or 30 cc. isotonic saline and 18 mg. heparin sodium, 1800 U.S.P. units.

The unit is designed to provide complete anticoagulant protection of blood for not more than 24 hours, during extracorporeal circulation in cardiac surgery.

New Dosage Forms

Synkayvite, Roche Laboratories' water-soluble vitamin K analog, is now available in two new dosage forms: 1 mg. and 2.5 mg., designed for administration to the infant immediately after birth, for the prevention of hemorrhage.

In addition to the new strengths, Synkayvite comes in ampuls of 5, 10, and 75 mg., and in 5 mg. tablets.

Anticholinergic-Tranquilizer

Pathibamate, recently introduced by Lederle Laboratories, is a combination of the anticholinergic Pathilon and the tranquilizer meprobamate.

It is recommended by the manufacturer for duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis with gastrointestinal symptoms, and gastric hypermotility.

Each Pathibamate tablet has 400 mg. of meprobamate and 25 mg. of Pathilon.

Tetrex Syrup

Tetrex Syrup, a product of Bristol Laboratories, is a tetracycline (phosphate-buffered) syrup, suggested by the manufacturer for use in a wide variety of infections due to tetracycline-sensitive organisms, and for prophylaxis in surgery and obstetrics.

Each teaspoonful (5 cc.) contains tetracycline (phosphate-buffered) syrup equivalent to 125 mg. of tetracycline HC1.

The product is supplied in bottles of 60 cc.

Atherosclerosis Control

Lufa, recently released by U.S. Vitamin Corp., combines unsaturated fatty acids (from safflower seed oil) with a complete lipotropic mixture.

It is recommended by the manufacturer for the control of hypercholesterolemia and atherosclerosis.

Each capsule contains 378 mg. unsaturated fatty acids; 2 mg. pyridoxine HC1, 233 mg. choline bitartrate, 110 mg. dl, methionine, 40 mg. inositol, 87 mg. desiccated liver, 1 mcg. vitamin B_{12}, and 3.5 I.U. vitamin E.

Lufa is supplied in bottles of 100, 500, and 1,000 capsules.

Cold Tablets

Neo-Synephrine Compound cold tablets, for treating the common cold and allergic and vasomotor rhinitis, chronic sinusitis, and influenza, are now available nationally from Winthrop Laboratories.

Each tablet contains 5 mg. of the nasal decongestant Neo-Synephrine hydrochloride, 150 mg. of the analgesic-antipyretic acetaminophen, 7.5 mg. of the antihistaminic drug, Thenfadil hydrochloride, and 15 mg. of caffeine.

Tablets come in bottles of 100.

a superb aid[1]
in helping to prevent
and clear up
BED SORES
(DECUBITUS ULCERS)

DESITIN®
OINTMENT

Good medical and nursing care, and Desitin Ointment make an effective team in keeping the patient's skin soft, supple, and better able to resist and help heal bed sores. And for a very good reason: Desitin Ointment is effective in guarding against irritation which causes pressure sores. Its soothing, lubricant and healing influence is so persistent that one application protects the skin for hours.

SAMPLES on request
DESITIN CHEMICAL COMPANY
812 Branch Ave., Providence 4, R. I.

1. Grayzel, H. G., and Schapiro, S.: Western Journal of Surgery, Obstetrics and Gynecology, Oct. 1956.

clinical notes

Hospital Infections

Staphylococcic infections resulting from cross-infections within hospitals may be the most serious current communicable disease problem today, write Wysham and Kirby in the *J.A.M.A.* 164:1733-39.

Such infections seem largely preventable, and strong emphasis should be placed on specific preventive measures, they declare. Re-emphasis on strict aseptic technic, including preoperative and postoperative patient care, appears indicated.

The authors studied 189 patients who had such infections within a three-and-one-half month period. In 100 cases, the infections appeared during hospitalization, and in 32 they appeared within 60 days of discharge.

It is probable that most of the latter group were also acquired as a consequence of hospital admission, the authors point out, since 91 percent of the organisms isolated from this group showed antibiotic-resistant patterns resembling those of organisms isolated in infections appearing in hospitalized patients. Also, the interval of less than 60 days from hospitalization to infection is within the latent period of micrococcic (staphylococcic) infection.

Twenty-four deaths occurred in the entire group—21 in the group of patients whose infections appeared during hospitalization.

Twenty-six of the 100 hospital infections were surgical wound infections. Five patients with such infections died, and in all five the wound infection was a contributing factor or major cause of death.

A problem almost equal to the total incidence of hospital-acquired infections is the apparently increasing resistance of such infections to antibiotic therapy. In the patients whose infections appeared within the hospital or after discharge, over 20 percent of the organisms cultured were resistant to all of the currently-used antibiotics except bacitracin. This increasing resistance also reduces the chances for success of prophylactic chemotherapy.

Any break in the skin, surgical or traumatic, including that made by intravenous catheters, appears to open the way for micrococcic invasion, according to the authors. Debilitated patients, especially those in coma, are evidently unusually susceptible to pneumonia and skin infection. Newborn infants appear to have little resistance to micrococcic infection, and invasion may be through normal, intact skin.

Because micrococcic infections are probably contagious, the authors point out, patients with such infections should be isolated whenever possible, for the protection of both patients and personnel. Contaminated bedding could be an important cause of nasal carriers among personnel, of micrococcic pneumonia, skin infections, and infections of poorly healing wounds, and therefore mattresses should be effectively covered and the covers cleaned between patients, and blankets should be laundered frequently and preferably sterilized with each laundering.

The authors comment that since their study was performed in a county hospital caring chiefly for indigent patients, probably the proportion of elderly and debilitated patients is far higher than in most private hospitals.

The fact also that crowding of patients may be greater in public than in private hospitals causes them to conclude that the incidence of micrococcic infection in most private hospitals would not be comparable to the incidence found in their study.

(Continued on page 135)

MISS PHOEBE

NO. 19 IN A SERIES

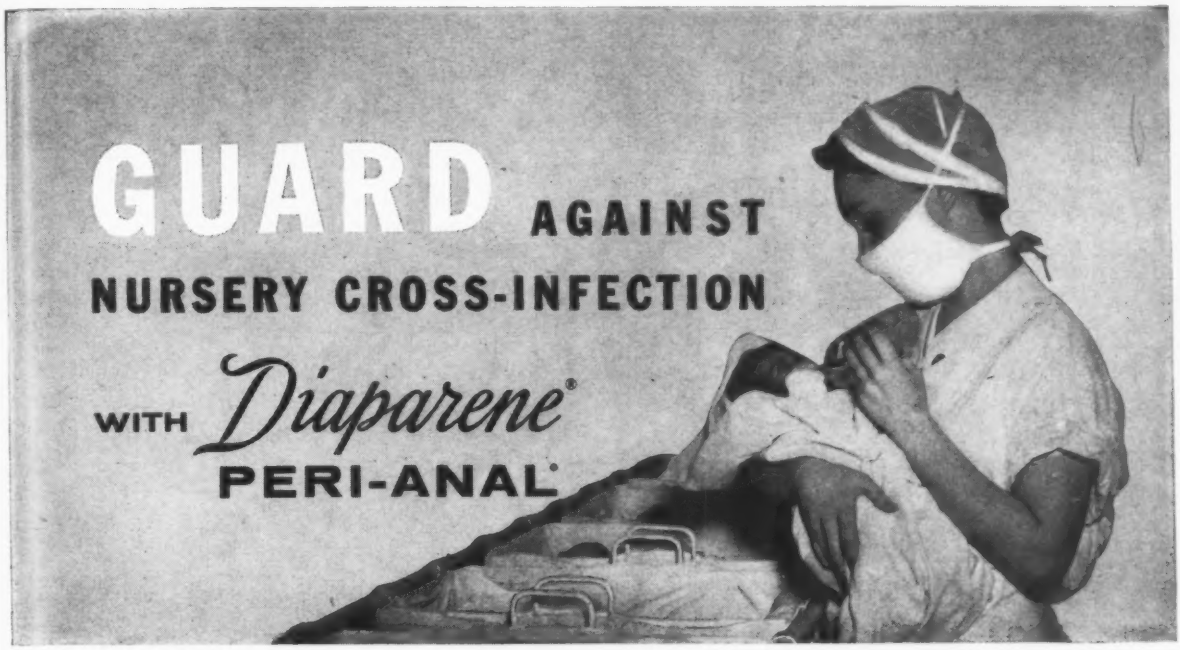
". . . so I said, Let's just *see* if it can out maneuver an E&J!"

E&J

Maneuverability means easier handling—one of the reasons both patients and hospital personnel prefer E&J chairs. But even dearer to hospital hearts and budgets is the fact that E&J chairs require little or no maintenance—they practically *refuse* to wear out. Over the years they prove to be your most economical buy.

Specify **EVEREST & JENNINGS** chairs for your hospital

EVEREST & JENNINGS, INC., 1803 PONTIUS AVE., LOS ANGELES 25, CALIF.



NOW AVAILABLE IN INDIVIDUAL ½ OZ. PACKAGE TO CONFORM WITH THE NEW YORK STATE SANITARY CODE

- ANTI-BACTERIAL
- ANTI-ENZYMATIC
- COD LIVER OIL FORTIFIED
- WATER-REPELLENT

NEW!

½ OZ. INDIVIDUAL NURSERY PACKAGE

Supplied only to hospitals.
(No drug store sales.)

$2.00 per dozen
(packed in 6 doz. cartons)

THE NEW YORK STATE SANITARY CODE

Regulation 35: Precautions to be observed for control of diarrhea of the newborn.

C.3.g. Individual equipment . . . shall be stored at each infant's bedside and all routine nursing care shall be given to the infant at the bedside.

- INDIVIDUAL TUBE FOR EACH INFANT
- SAVES TIME — NO MESSY REPACKAGING
- NO CROSS-INFECTION
- ECONOMICAL

PROTECT AGAINST NEWBORN "SORE-BOTTOM"

DIAPARENE PERI-ANAL has proved highly effective in the prevention and control of peri-anal dermatitis (sore-bottom in the newborn caused by loose, transitional stools).[1]

ACTIVE INGREDIENTS: di-isobutyl cresoxy ethoxy ethyl di-methyl benzyl ammonium chloride monohydrate, zinc oxide, starch, cod liver oil and casein in a water repellent base.

[1]Grossman, Leo, St. Francis Hospital, Miami Beach, Fla., "A New Specific Treatment for Perianal Dermatitis", Arch. Ped., 71:173-79, June, 1955

MAIL YOUR ORDER TODAY!

Diaparene DIVISION
HOMEMAKERS' PRODUCTS CORP.
ENGLEWOOD CLIFFS, NEW JERSEY

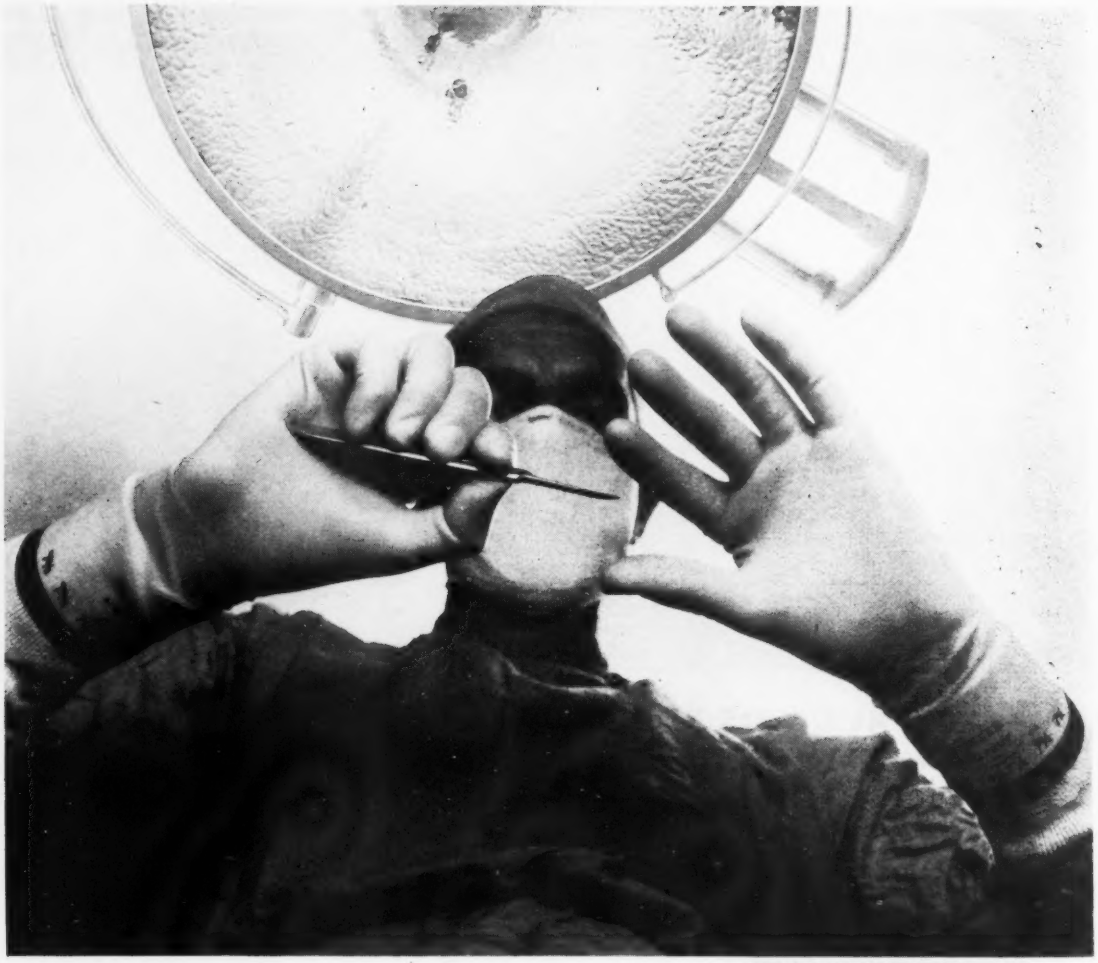
YES, DIAPARENE . . . Please rush us _____ dozen tubes of Diaparene Peri-Anal @ $2.00 per dozen, for use in our newborn nursery to prevent "sore-bottom" and protect against cross-infection.

HOSPITAL_____

CITY_____ ZONE_____ STATE_____

STREET_____

AUTHORIZED BY_____



Rollpruf® Surgical Gloves by PIONEER

RP-158 Tissue-thin Flat Banded White Latex.

RP-169R Brown Latex with Non-Slip *Fingers and Palms.*

RP-168 Tissue-thin Flat Banded Brown Latex.

75-LW Green Neoprene for persons allergic to rubber.

- . . . Flat-Banded Cuff Won't Roll Down During Surgery
- . . . Pair for Pair Uniformity Within 1/1000th inch
- . . . Quality-Made and Individually Inspected

the PIONEER Rubber Company
328 Tiffin Road, Willard, Ohio

Pioneers In Surgical Hand Protection for over 35 Years

A British physical therapist tells how her specialty can contribute to a more relaxed labor and delivery and help prevent gynecological problems

By Mrs. Eileen Montgomery**

*The Physical Therapist on the Obstetric Team**

● In all parts of the world today, there are varying attitudes toward childbirth among peoples of many races with widely differing modes of behavior, some natural, some artificial.

Even among the African people, where we have been led to believe that the women produce their children with little effort and without the pains or the problems associated with our artificial civilization, I understand that, just like women anywhere else in the world, they all react differently. The Kikuyan women, for example, accustomed to doing a large share of the manual work of the tribe, are very hardy and usually have their babies quietly and easily, whereas the Jalou wives who are pampered and spoiled by their menfolk usually make a great deal of fuss.

Life, as it is lived, either by so-called "primitive" or by civilized people, does influence the body formation and behavior. Up to a point, we behave as we think we are expected to behave.

In our Western culture, too, there are many divergent paths of approach. There are some normal women who regard themselves as entirely passive pieces of mechanism. They ask to be anesthetized or to be deeply drugged and are so deprived of the power to take an active part or to remember the important event. In these cases the deliveries would be instrumental, voluntary expulsion being impossible, and the mothers would probably choose to bottle-feed their infants, so the milk secretion would be suppressed.

This passive conception of labor is the direct opposite to the one in which many obstetricians, midwives, physical therapists, and parents are taking a keen interest.

Here the patient practices certain postures and movements which enable her, well in advance, to adapt herself to the stresses and strains of pregnancy, and which fit her for her coming athletic feat.

She is made fully aware, beforehand, of how the baby will be born, what sort of sensations she is likely to experience throughout the labor, why certain ministrations will be carried out as routine, and what kind of directions she will receive.

She realizes that she can assist the course of labor by her own natural resources, and she rehearses regularly with her instructor, so that when the time comes, her performance will be more coordinated and much more satisfactory.

To be 100 percent effective in practice, this method calls for complete unity of purpose between all members of the obstetric team. If during parturition the patient encounters attendants who are obviously indifferent or hostile to the idea, her confidence may collapse completely.

As long ago as 1927, Dr. Grantley Dick Read, the British doctor who was one of the pioneers of this trend, taught us that fear leads to tension, which in turn causes pain. From this, we should deduce that where there is no fear there will be no pain.

We can all agree that a well-trained mother should, in normal circumstances, bear her baby with the minimum of pain, but certain discomforts are undoubtedly due to nerve pressures. The patient who knows that such pressures may normally occur will take the resulting pain in her stride, confident that it is unlikely to last long; whereas, if she has been misled into believing that labor should be painless, this in itself will cause anxiety should pain be felt, either because she doubts her own normality, the efficacy of the training methods, or her own ability to carry out what she has been taught.

We must realize, too, that there may be no fear of labor itself, yet fear may be there, deep down, and intimately connected with the approaching birth in some way. Financial worry, fear of responsibility, loss of freedom or physical attraction may be unrevealed fears.

For a few, then, this psychosomatic approach will not succeed, but for the majority it will be rewarding.

The idea has spread to all parts of the world, more quickly in some places than others. Many countries have developed it, though not along the same lines. Communities have characteristic and individual needs, just as each patient has.

Recently, the Pope has approved the principle from the moral point of view. We are told that the Russians claim to have evolved such a method—though by a different name, "psychoprophylaxis" — and to have used it on

(Continued on next page)

*Reprinted with permission from *Proceedings of the Second Congress*, World Confederation for Physical Therapy, published by the American Physical Therapy Association. The Congress was held in New York City, June 17-23, 1956.

**Mrs. Montgomery is a chartered physiotherapist in Bristol, England.

500,000 women in Russia and 200,000 in China. One British doctor, when visiting Moscow to see it in operation, was told, "We like the method. It has not made much difference in the statistics, but it certainly changed the acoustics!"

There have been many controlled experiments; some seeking to prove reduction in the use of anesthetics, analgesics, and drugs; some to reduce the duration of labor, some the incidence of episiotomies, perineal tears, instrumental deliveries, and operative interference. In my opinion, however, such claims are better discussed exclusively in professional circles, for if they are made at the patient's level, they may induce a spirit of competition which could be detrimental and lead to feelings of failure and incompetence later on.

In any case, these procedures are outside the scope of the physical therapist. We have our place on the obstetric team as an influential adjunct to all that the science of midwifery has to offer, and our aim should be to enable the mother to cooperate in the conduct of her quick or prolonged, easy or difficult confinement, to the best of her own ability.

The early application of physical therapy in obstetrics was postnatal. The aim, then, was to maintain muscle tone during a prolonged stay in bed, followed by graduated exercise to restore function to normal.

In later years we came to give assistance in certain digressions from the normal, such as cesarean section, chest and circulatory complications, sacroiliac and pubic strain. Rays and electrotherapy were also found to be useful in treating certain conditions associated with maternity.

During the past few years, there has been a shift of emphasis, which started with the shortage of beds in our surgical wards. Surgeons began to order preoperative preparation for their patients, and it soon became obvious that, when so prepared, patients not only felt better on getting up, but they regained their normal function more quickly. Perhaps even more important was the preventive effect of such treatment. The incidence of chest and circulatory complications was greatly diminished.

A similar change of approach in obstetrics can have far reaching preventive effects. On the physical plane, good neuromuscular control lessens the risk of straining the supports of the abdominal and pelvic viscera, the cause in so many women of backache and feeling "weighed down." It also lessens weakness and bulging of the vaginal walls, stress incontinence, loss of sexual appreciation, and prolapse. On the mental plane, it has been suggested that it makes for improved family relationships all around.

ANTENATAL PROGRAM

At the Bristol Maternity Hospital, our training program includes the now popular technic of teaching general relaxation through sensory appreciation of muscular tension in every muscle group of the body.

Controlled breathing with a sigh on expiration according to the natural respiratory rate of each person is, in my opinion, the key to relaxation under difficult conditions.

If patients are to become proficient enough to be able to relax automatically during contractions towards the end of the first stage and during the transition, practice is essential. It is a skill which, like learning to play a musical instrument, requires concentration and habitual repetition to attain perfection in execution.

Though I am convinced of the effectiveness of relaxation used at the right time, I am equally convinced that used at the wrong time, it may actually cause delay. In early labor the patient will think less about herself if she is occupied. From the mechanical viewpoint, gravity can assist the fetus down into the pelvic basin if the trunk is upright, and it has been my experience that women usually prefer not to recline unless the fetus is well down in the pelvis.

We train the patient to adapt her breathing to her own necessities during her labor. She is taught to breathe with the bases of the lungs until it is no longer possible (towards the end of the first stage), and to pant slowly and deeply, as if out of breath—still with a sigh, but using upper and middle lobes—for use with the analgesic mask, or if there is an urge to bear down before full dilatation of the cervix.

We teach exercises (1) for maintaining good posture, with special emphasis on pelvic tilting; (2) for promoting muscle tone with elasticity (I believe that the tempo of the movement is important. Never do we hold any muscle in a state of full contraction for more than a second, and the movements are slow and rhythmical); (3) for improving suppleness of pelvic and spinal joints, and getting the patient accustomed to the positions she will be required to adopt during the second stage; and (4) for educating the pelvic floor muscles to produce the finest degree of control, plus elasticity.

The so-called "levator platform" consisting of iliococcygeus and pubococcygeus proper, where the fibers blend in midline, should lie almost horizontally to support the uterus, when in the erect standing position.

The medial and intermediate fibers of pubococcygeus (which some anatomists call pubovaginalis and puborectalis) divide on either side of the vagina and the anorectal junction, to form U-shaped slings. There are minute insertions into the walls of both structures, and also to the urethra and perineal body.

In some women, even before their first pregnancy, these muscles are weak and toneless, sometimes enough to alter the angle of the platform to a pronounced incline. Yet we know that the muscles play an important part in the second stage of labor, in directing the presenting part downward and forward, along the birth canal. When the fetal head is almost crowning, the perineum bulges, the pubococcygeus relaxes with the anal sphincters, and the levator ani is drawn up over the oncoming head.

If the muscles fail to relax at the appropriate time, there may be damage to the pelvic floor. It is the medial fibers which are in the most vulnerable position and if they are severely stretched or lacerated, then the distressing conditions previously mentioned may result.

What will happen, then, to the not uncommon type of woman who has neither conscious awareness nor the ability to contract and relax the pelvic floor? Will she be more likely to suffer injury during labor, and if so, can we reduce such a probability?

During the second stage the mother will require a pelvic floor which is neither too tense nor too relaxed. She will be more likely to acquire this necessary neuromuscular control if, during pregnancy, she practices pure contractions of the muscle, quite independently of any tensing of the glutei, adductors, or abdominal muscles.

The patient sits on a low stool or seat with knees wide apart. She leans forward and rests elbows on knees.

(1) She contracts as if to control the bowel and relaxes completely.

(2) She contracts as if to control the bladder and relaxes.

(3) She contracts the levators and "draws up" inside the vagina and anus and relaxes.

In this way, she is made aware of the slight difference in sensation as each part of the pelvic floor is tensed, and she is conscious, in such a position, if she "cheats" unwittingly and uses other muscles.

Occasionally, women are unaware, even after trying this exercise, of any sensation of muscular tension in the pelvic floor itself. For them a tactile aid will assist further. When taking a bath, the patient lies in the water with hips flexed and outwardly rotated knees resting against the side of the tub. She places one or two fingers inside the vagina, and feels the grip as pubococcygeus is contracted and relaxed.

Associated contractions are, of course, none the less important, particularly those of obturator internus and piriformis, the glutei and abdominal muscles; but their value is enhanced still further if expectant mothers can learn to differentiate between such associated muscle work and an independent contraction of the pelvic floor.

COORDINATED RESPIRATION

The patients can also learn quickly how best to coordinate respiratory control and voluntary muscular effort for the second stage of labor.

We all have our individual ways of communicating ideas, but I have found that by imitating the mistakes that are commonly made, the group will more readily grasp the constructive advice which follows.

We are all too familiar with the type of patient who pushes in her throat instead of holding her breath and bearing down. There is also the one who pushes most efficiently, but who holds her breath too long. When, nearly blue in the face, she does eventually breathe in again, she does it with a gasp, draws in her abdominal muscles, and the baby slips back to the position it was in at the beginning of the contraction. Now, out of breath, she will be unable to regain respiratory control until the contraction has passed.

Not so the trained patient! She will be able to regulate her inspirations to her oxygen requirement—we do not all breathe at exactly the same rate, nor have the same lung capacity—and will be able to hold the downward push, by fixing the abdominal muscles while she breathes in; so making small advances without any retard, until the expulsive urge has passed.

So long as she goes with the urge, instead of resisting with the levators, it is not likely to be really painful, except perhaps just before crowning. At this point, due to pressure of the fetal head, the tissues in the surrounding area are becoming numb. As this is happening, she may feel a tingling or searing sensation for about half a minute. This to an unprepared woman is the moment of hazard. In panic she may resist the advance of the fetus by contracting the pelvic floor.

An informed woman who has practiced regularly will be able to relax, and though she may choose to use her analgesic for a few moments, she is fully aware of the sequence of events. For her it is the signal that the objective for which she has been striving will be accomplished in two or three more uterine contractions. She is ready to cooperate and follow her attendant's instructions for the delivery, being already proficient at panting softly in and out, to ensure that the baby arrives slowly and smoothly.

POSTNATAL PROGRAM

We begin gentle postnatal exercises the day after delivery, progressing gradually during the lying-in period.

We explain to each patient why it is important to restore the tone before taking on the strain of a normal household routine, and the exact purpose of each exercise. We are convinced that an exercise performed with this full understanding and coordination between mind and body will be of far greater benefit.

Home exercises are continued, at least until the routine postnatal checkup by an obstetrician, six weeks after delivery. The busy housewife will perform certain movements while actually doing the housework and cooking. Though at first this needs conscious effort, in a short time it becomes automatic.

Again, we place as much emphasis on re-education of the pelvic floor as on abdominal and postural muscles, believing that such a course may prevent displacements and save a woman years of pelvic discomfort.

Our obstetricians have found that, at six weeks after delivery, the number of patients with tendency to prolapse and stress incontinence has diminished since this more specialized type of physical therapy came to be used.

When these conditions do occur, more commonly following delayed second stage, forceps delivery, or precipitate labor, we use the faradic current to restore the tone to the pelvic floor. In such cases, it is fairly common for the woman to be incapable of performing an independent pelvic floor contraction until she has had special treatment. (Only about half of the booked patients attend the antenatal preparation classes, and many of the others are multiparous and have had babies elsewhere previously, or have some abnormality.)

Skeptics have argued that the faradic current does not strengthen, and therefore cannot help in these cases. It is not being asserted that it *strengthens*, but that it re-educates neuromuscular control and develops the perception of localized muscle work. When this has been accomplished, the patient herself will strengthen and shorten the muscle fibers by voluntary exercise tempered with resistance. Faradism, if necessary, should always precede active pelvic movements.

Method of application. The patient is placed on a treatment couch with head and shoulders raised to about 30°, with one pillow under the head, and another supporting the knees, which are abducted and outwardly rotated. In this position she will be able to relax.

A large indifferent electrode (about 8x6") with a rubber sheet beneath it is placed under sacral nerves 2, 3, and 4.

A sterilized vaginal electrode, lubricated with a non-greasy jelly, is inserted upwards and backwards into the vagina as far as the middle one-third (the position of pubococcygeus), and the current is turned on slowly and surged. It is important that the patient is given enough current without causing pain. The current will be felt first of all in the sacral region, in spite of the large area of electrode, because mucous membrane is less sensitive than skin.

(Continued on next page)

At first the contractions may be slight, but an uplifting movement of the perineum should be visible, and a contraction should be felt along the vaginal electrode.

When the pubococcygeus is stronger, the inserted part of the electrode is drawn towards the symphysis pubis, causing it to tilt with each contraction.

The duration of electrical treatment is 10-15-20 minutes, preferably three times weekly. If, however, the patient has a long journey to make, or if she finds attendance a physical or emotional strain, we feel that it will have a detrimental effect on her. Mother-child relationships and breast-feeding may suffer. In this case, we consider it preferable to treat the mother less often, even if it means continuation for a longer period.

Where there is stress incontinence, or weakness of the vaginal walls, without any obvious ballooning, two to 12 treatments are usually necessary.

If there is cystocele, urethrocele or rectocele, approximately 12 to 24 treatments will be required.

Even patients with a definite descent of cervix have been improved, but where the descent is advanced and of long duration physical therapy has not been found to give relief.

For assessment and as a visual aid, we use a vaginal resistance chamber attached to a sphygmomanometer.

The following figures show the results of a follow-up of all patients who were treated for weakness of pelvic floor muscles by the method described, between 1951 and 1955. (Deliveries average between 1,000 and 1,200 per year.) During April and May, 1956, the patients (50 in all) were asked to attend for assessment.

Armstrong X-P Baby Incubator

Designed as an explosion-proof incubator for use in the delivery room or surgery. Tested and approved by Underwriters' Laboratories. Send for free descriptive bulletin.

THE GORDON ARMSTRONG CO., INC.

504 Bulkley Building

Cleveland 15, Ohio • CHerry 1-8345

19 were not contacted (moved away; new address unknown).

6 had moved away but reported no further trouble.

25 were examined by a gynecologist.

Weak Pelvic Floor Muscles
Bristol Maternity Hospital
1951 - 1955

Results

Follow-up of 25 Cases
Treated by Faradism and Resistance Exercise

Excellent	12	Strong pelvic floor control. Normal parous vagina. No symptoms (1 subsequent pregnancy—no return of of either bulge or symptoms)
Good	8	Small bulge on bearing down, completely controlled by contraction of pelvic floor muscles. No symptoms (1 subsequent pregnancy—slight stress incontinence, rapidly improved with exercise)
Fair	3	Still rather lax though much improved. Symptom-free
Unsuccessful	2	Still lax with symptoms. Perineal control nil. (1 had 2° descent of cervix)

All had cystocele or rectocele (or both) causing symptoms.
25 cases assessed originally and at follow-up by gynecologist.

In this way the physical therapist, the acknowledged expert on muscle work, with her more positive approach to health and body mechanics, has become a useful member of the obstetric team.

During pregnancy, group teaching has certain advantages over individual tuition. The patients enjoy meeting, in a friendly atmosphere, others who are having similar experiences. The nervous and tense ones especially are observed to change their outlook, both by their behavior and by their facial expression.

PROFESSIONAL LIAISON IMPORTANT

Close liaison between the physical therapist and the other professional team members is essential for success. If the physical therapist plays her part well, her presence will not be needed by the patient in labor, though obviously we must be able to observe patients to assess the result of our work and make improvements if necessary.

Very few women have found their first confinement absolutely painless, but many have expressed the view that they are glad to have experienced every phase with competence and understanding.

To most women, whether they construe their uterine contractions as painless, painful, or merely uncomfortable, their sensations, quickly forgotten, will matter far less than the ultimate result.

It is in the preventive field that physical therapy has much to offer the obstetric patient antenatally, during the lying-in period, and postnatally in restoring postural tone and the feeling of well-being that goes with it.

If we can save some women from pelvic discomfort and reduce their risks of ending up in a gynecological unit, then all will agree that, like the Boy Scout, it is better to "be prepared."

Newborn Nursery Features 'Floating Babies'

Babies are floating on clouds, and a fully loaded stork pops out of the walls of the newborn nursery at Bishop Clarkson Memorial Hospital, Omaha, Nebr.

The wall murals, shown here, were specially designed and hand-painted in oils on a kind of canvas called "Sanitas." They are applied to the wall with wallpaper paste and can be scrubbed with soap or detergent and taken down and rehung, according to the artist, Dick Nell, New York City.

Colors were selected to blend with the interior. The nursery walls are off-white with a slight pink tint. The clouds are blue, and the babies are blondes, brunettes, and redheads.

The murals were the gift of Mrs. C. C. Criss, with the cooperation of Mrs. Joseph P. Muller, chairman, Ralph Redfield, and Robert Storz of the Clarkson Service League decorating committee.

Care of Premature Infants Subject Of New York Institutes

Care of premature infants will be stressed at the New York Hospital-Cornell Medical Center institutes for physicians and nurses.

The institutes, beginning September 30, November 18, 1957, and January 6, 1958, are sponsored by the New York State Department of Health and the United States Children's Bureau.

Attendance at each institute is limited to six physician-nurse teams. The program is two weeks for physicians and four weeks for nurses.

Subjects covered are: physiologic handicaps and metabolism of the premature infant, obstetric aspects, control of infection, hematology, pathology, retrolental fibroplasia, construction of the premature unit, nursing management, parent education, community follow-up, and social service.

Demonstrations include delivery room and resuscitation methods, use of incubators and heated cribs, technics of feeding and methods of suction. Also included are field trips to premature nurseries, and a home visit with a public health nurse.

Participants pay no tuition fee. Stipends are provided to help cover expenses during attendance at the institutes.

Additional information may be obtained by writing Box 143, Institute in the Care of Premature Infants, The New York Hospital, 525 E. 68th St., New York 21, N.Y.

Warns of Danger of Lawsuits If Precautions Not Used

The medico-legal importance of having a nursery staff well-informed about precautionary measures against retrolental fibroplasia was pointed out in a recent editorial by Nicholas J. Eastman, M.D., editor, *Obstetrical and Gynecological Survey.*

"From a medico-legal viewpoint as well as for other reasons it is extremely important that nurses in newborn nurseries be familiar with methods for testing the ogygen concentration in incubators and be instructed to carry out as well as record these concentrations two or three times a day," he said.

"If this is not done, and if a premature infant subsequently develops retrolental fibroplasia, the burden of proof would be on the hospital to prove that the infant did not receive excessive concentrations of oxygen. Indeed, the etiologic role of high oxygen concentrations in this disease is so firmly established that we would all be inclined to suspect that any such infant had been exposed to excessively high oxygen mixtures."

The Book Corner

Standard Text Revised

HOSPITAL ORGANIZATION AND MANAGEMENT. By Malcom T. MacEachern, M.D. Chicago: Physicians' Record Co. 3rd ed. 1957. 1,316 pp. $18.75

The newest edition of *Hospital Organization and Management* places this text in the forefront of hospital administration reference material. This revision accomplishes a number of things:

(1) It brings up to date material previously covered.

(2) Specific subjects are made easy to locate.

(3) Administrative problems and their solutions are stressed.

(4) Principles of hospital and medical administration are discussed.

Material from the second edition has been clarified through better sectional groupings. Better flow charts have been added to assist understanding of the text. Addenda on procedures have been revised, expanded, and placed in better sequence. The following sections are particularly improved in this respect:

Suggested bylaws, rules and regulations for a voluntary hospital

Forms necessary for the patient's chart

Bylaws, rules and regulations for women's auxiliaries

Rules and regulations for the resident staff.

Certain sections which have undergone change in emphasis or are controversial in nature have been clarified and expanded, and solutions have been advanced. These areas include:

Consultations and their importance
Colors in the hospital plant
Safety in operating rooms
Medical record-keeping
Physical therapy and rehabilitation
Inhalation therapy
Diet control
Medical staff organization
Anesthesia
Central supply services.

Newer services and administrative concepts have been inserted. These include:

The recovery room
The medical audit
Budget planning
Personnel department
Chiropody
Radioactive isotopes.
Accreditation of hospitals (new chapter)
Insurance.

The most significant change in this edition is the shift in concept of emphasis on medical staff to equal emphasis on other aspects of medical administration. The following quotation demonstrates this change:

> **"The medical staff is the chief agency through which the hospital achieves its prime purpose, that of the proper care of the sick and the injured. This position of importance does not, however, make it supreme and independent within the hospital. Both the governing board of the hospital and the community which it represents exercise effective control over it."[1]**

A similar concept is expressed in the discussions of the admitting department, the accreditation of hospitals, internal and external public relations, and insurance and accounting.

[1]Chapter 6, "The Medical Staff," p. 157.

the new ZIMMER
OCTAGON ALUMINUM
SIDE ARM TRACTION FRAME
NO. 908
Attaching simply to the springs of the bed, the new Side Arm Traction Frame eliminates the need of keeping the patient stationary while in traction. With this new frame the back rest of the bed can be raised or lowered, yet the traction remains unchanged.
This new frame may also be fastened near the end of the bed for traction on the leg or foot.
As this Side Arm Frame is assembled from component parts of our No. 640 Overhead Frame, all that is required if the hospital already has a No. 640 and a No. 641 frame is one No. 908-01 Base Clamp Assembly.
NO. 908 SIDE ARM TRACTION ASSEMBLY CONSISTS OF:
1 908-1 Base Clamp Assembly
1 908-03 27" Traction Arm
(1 640-3B 27" Traction Arm may be used)
1 640-3A 36" Traction Arm
1 640-3D 9" Traction Arm
3 640-4 Pulley & Clamp Assembly
(No cords or weights furnished)
FIRM, NO-SLIP ANCHORING
The octagon clamp provides firm anchorage of cross arms without marring tubing.
TOGGLE CLAMPS
as used with the complete 640A Octagon Aluminum overhead frame.
zimmer
LOOK FOR THE TRADEMARK
ZIMMER MANUFACTURING CO. • WARSAW, INDIANA, U. S. A.
In Canada Available through selected surgical supply dealers or through our Agents, Fisher & Burpe, Ltd.

Legal aspects receive greater emphasis in this edition. Some very practical solutions are offered. For example:

"In some states, however, the vested interests of inferior practitioners are protected by law in government-controlled hospitals. In such hospitals the governing board is handicapped in its choice of physicians to attend the patients of the hospital. Practitioners with inferior training are permitted free access to the hospital facilities, and their privileges are unlimited. A comparison of the results achieved by inferior practitioners with those produced by competent physicians should convince the most skeptical that there is a marked difference in quality of medical practice that should be brought to the attention of the public. Such comparisons are seldom made, and, when they are made, the findings are not made public. . .

"Since the powers of the governing boards of some public hospitals are restricted by law, the remedy must be found in law. The governing boards of public hospitals must be given the power to discriminate between the competent and the incompetent practitioners of the healing arts. . . . . "[2]

This textbook emphasizes the historical change in the hospital from the "workshop of the physicians" to the "controlled social agency which provides care of the sick and injured of the community."

It should immediately replace the older reference text.—**Nick Karabaich, R.N.**

[2]Ibid., p. 163.

Officers of Tri-State Assembly Announced

The board of directors, Tri-State Hospital Assembly, recently elected the following officers: A. C. Kerlikowske, M.D., director, University Hospital, Ann Arbor, Mich., president; Sister Mary Reginald, assistant director, hospitals, Sisters of Mercy, Detroit Province, Dyer, Ind, vice-president, and Leon C. Pullen, Jr., administrator, Decatur and Macon County Hospital, Decatur, Ill., secretary. Riley McDavid, administrator, Kenosha (Wis.) Hospital was re-elected treasurer.

The three-member staff was re-elected: Albert G. Hahn, executive director, and Mrs. Albert G. Hahn, associate executive director. Mr. Hahn is administrator and his wife assistant administrator, Protestant Deaconess Hospital, Evansville, Ind. Leo M. Lyons was re-elected program director.

Costa Rican Hospital Association Meets

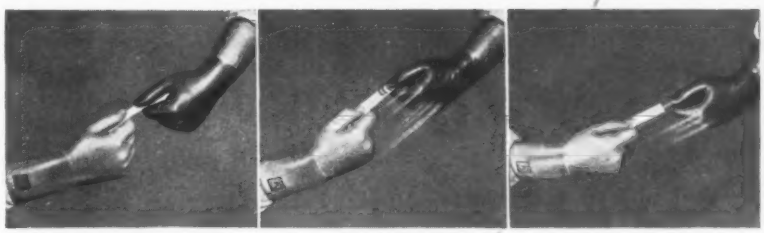
Administrators, doctors, and nurses at the second Costa Rican Hospital Congress elected Fernando Quiros Madrigal, M.D., director, Asilo Chapuf, president; Carlos Arrea B., M.D., director general, Asistencia Medico-Social, president-elect José María Barrioneuvo, administrator, Asilo Chapui, secretary, and Arturo Arias J., contador, Dirección General de Asistencia Médico-Social, treasurer.

Slide Films Help Show Patients What is Wrong

John B. Gregg, M.D., a Sioux Falls, S.D. otolaryngologist, has found slide films a helpful method of educating patients.

Writing in the *J.A.M.A.* (Vol. 164:11), Dr. Gregg says that interview time can be cut by one-third to one-half with use of pictures. Pictures also help the patient to better understand his ailments, and in some cases have convinced patients of the need for operations, and helped allay needless fears.

try this traction test...



Put a MATEX Dermatized glove on one hand—a smooth glove on the other. Wet both gloves. Grip smooth surface.

With equal pressure for both hands, pull in opposite directions.

The MATEX Dermatized glove holds. The smooth glove slips off.

to learn why

THERE'S LESS TRAUMA WITH MATEX DERMATIZED GLOVES

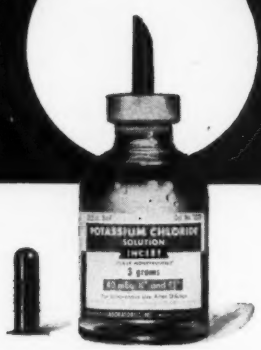
The skin-like texture of MATEX Dermatized gloves gives twice the grip on wet instruments or tissue as is possible with smooth gloves. With MATEX Dermatized, the surgeon exerts less pressure to maintain a secure grip—tissue suffers less trauma—protracted surgery is less tiring.

Write to MASSILLON RUBBER Company for free kit to demonstrate this test yourself.

MATEX Kurikoort MASSILLON LATEX

The MASSILLON RUBBER COMPANY
Massillon, Ohio

INCERT®



new... unique one-step additive vial saves time, labor and money in your hospital

NO AMPULES... NO NEEDLES ...NO SYRINGES

Simply remove tamperproof cover of INCERT and push sterile plug-in through large hole in stopper of solution bottle. It's that easy... and a completely closed, sterile system.

EXCLUSIVE HOSPITAL-USE FEATURES

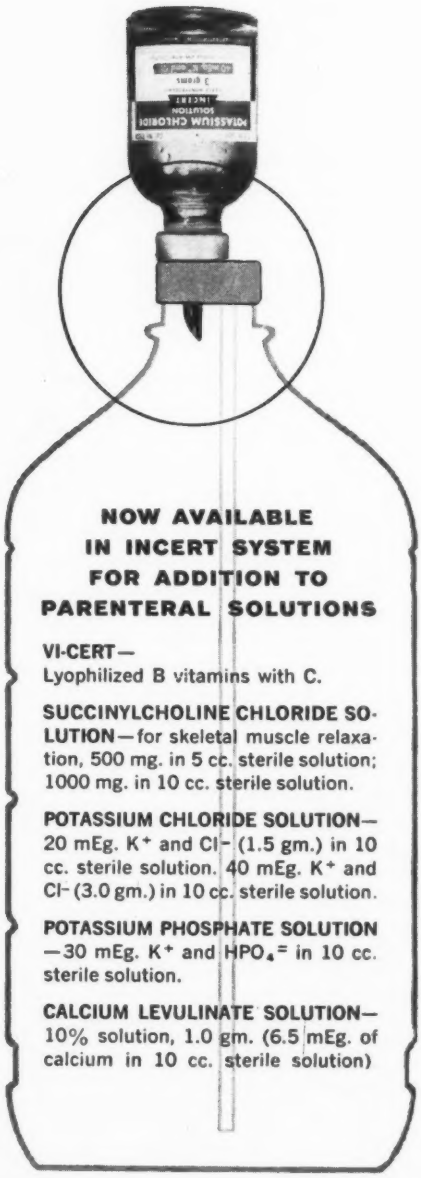
CONSERVES TIME — Instantaneous automatic supplementation of bulk parenteral solutions.

COMPLETELY STERILE—Closed system, from preparation to administration.

ECONOMICAL—Cuts labor and expense by eliminating ampules, needles and syringes.

SIMPLE TO USE—A foolproof system that eases the hospital care load.

***INCERT SYSTEM** is an original development of Travenol Laboratories, Inc. Complete literature and samples on request.*



NOW AVAILABLE IN INCERT SYSTEM FOR ADDITION TO PARENTERAL SOLUTIONS

VI-CERT—
Lyophilized B vitamins with C.

SUCCINYLCHOLINE CHLORIDE SOLUTION—for skeletal muscle relaxation, 500 mg. in 5 cc. sterile solution; 1000 mg. in 10 cc. sterile solution.

POTASSIUM CHLORIDE SOLUTION—20 mEg. K^+ and Cl^- (1.5 gm.) in 10 cc. sterile solution. 40 mEg. K^+ and Cl^- (3.0 gm.) in 10 cc. sterile solution.

POTASSIUM PHOSPHATE SOLUTION—30 mEg. K^+ and $HPO_4^=$ in 10 cc. sterile solution.

CALCIUM LEVULINATE SOLUTION—10% solution, 1.0 gm. (6.5 mEg. of calcium in 10 cc. sterile solution)

TRAVENOL LABORATORIES, INC. MORTON GROVE, ILLINOIS

Pharmaceutical Products Division of **BAXTER LABORATORIES, INC.**

Pediatrics

Emphasize Personal Aspect In Care of Handicapped

By Anne Seymour, R.N. and Pauline Wright, R.N.*

Removing a splinter from a towhead's finger, granting permission for the older boys to watch football practice, answering requests for such assorted items as string, rubber bands, paper, pencils, scissors and cardboard, are only a few of the duties confronting us at the nurses' station between 4:30 and 5:30 on week-day afternoons.

When the student-patients at the Hospital School for Severely Handicapped Children are through with classes and therapies at 4:30, they run, push each other in wheel chairs, or hurry on crutches to the sunroom where they meet their "Big Brother" or "Big Sister," university students who play with the children, take them shopping in town, or for rides in the country.

For an hour there is the noise and laughter of children expressing their personalities through varied types of recreation. Some will want to go down to the industrial arts shop. Others will want to play Elvis Presley records. Some are climbing enthusiasts, and we find them on top of the mantlepiece. We have over 40 children living away from home, and it is up to the nursing area to furnish as homelike an atmosphere as possible as well as to care for daily health needs.

The Hospital School is part of the State University of Iowa Medical Center, and is the only institution of its type in the country that is administered by a state university.

*Supervisor of Nursing, Hospital School for Severely Handicapped Children, State University of Iowa, Iowa City.

Jane Wehrkamp sees that three of the children reach their next class or therapy on time. The children are shifted from one area to another every 45 minutes. Aides and orderlies are assigned to each classroom group to help avoid traffic jams in the hallways.

We have bed space for 50 children, and a full enrollment of 60, which includes day students. Our goals are to provide for the general care and welfare of the children 24 hours a day; to meet their physical and emotional health needs; to work with other departments to maintain the Hospital School program; to provide guidance and counsel to parents concerning the children's health needs; to provide an educational program for persons interested in the nursing of severely physically handicapped children, and to support ongoing research studies and provide opportunities for research in the nursing of physically handicapped children.

In the two-year period, September 1952-54, in addition to their academic work, the children received 8,012 occupational therapy treatments, 7,605 physical therapy treatments, 8,508 speech therapy treatments, and 5,790 physical education treatments. By July, 1956, there had been a total of 1,856 outpatient visits by parents of handicapped children for evaluation, examination and recommendation.

In addition, 1,138 university students in speech pathology, occupational therapy, physical therapy, education, physical education, music, child welfare, medicine, and nursing received part of their practical training here for varying periods. All areas have observation rooms with one-way glass and loudspeakers.

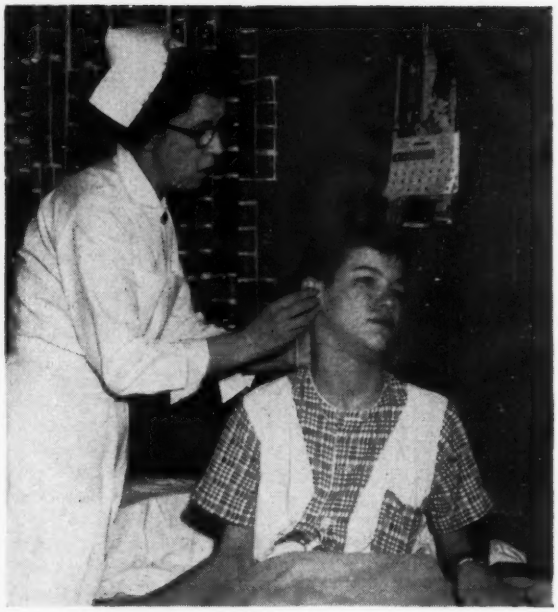
Children are accepted on these bases: their need for therapy and the special education provided at the Hospital School, their ability to profit from the program, their educability, degree of physical severity, and tenure of application. Some children are so severely handicapped that they cannot profit as much as the more moderately handicapped.

When it is established which ones are going to benefit most, we have to choose children to fit into the program. We like to have between 10 and 12 in each of the five divisions: kindergarten and pre-school, beginning primary (starting reading); primary (high first and second grades); advanced primary (second through fourth grades), and intermediate (fifth through eighth grades).

Children in the kindergarten and pre-school group attend for three months at a time. First through eighth-graders have an academic program lasting nine months.

We also have a nursery for children 3 years old and under. We have four of them at a time, here for a month to six weeks, then home for six weeks, depending on the skills acquired and whether they can practice skills at home.

(Continued on next page)



Mrs. R. E. Myers, R.N., puts hearing aid on a patient confined to his bed with a cold.

PEDIATRICS continued

Their handicaps include all types of cerebral palsy, spina bifida, rheumatoid arthritis, muscular dystrophy, postpolio, postencephalopathy, arthrogryposis, osteogenesis imperfecta, amyotonia congenita, congenital deformities, and other crippling conditions.

Everything is paid for by the state except medical expenses, which are paid for by the family on the same basis as if the child were not in school, i.e., on an indigent, cost, or private basis. Parents furnish all clothing and transportation, plus $15 each semester. Five dollars of this amount goes into a recreation fund for movies on week-ends, and $10 is kept for the students to spend on personal items such as barrettes, hair ribbons, kites, or toys and hobbies.

DIFFERENT NURSING ASPECTS

Numerous aspects of nursing in an institution such as ours differ widely from nursing practices in a general hospital, or in a unit for physically ill children. Some nurses here have felt that they had little opportunity to use such nursing skills as those needed for acutely ill or post surgical patients. Supervisory activities occupy more time, and the nurse does very little physical nursing care.

Nursing service provides the link between the educational and therapy programs. We are primarily responsible for the emotional and health needs of the students between 4:30 p.m. and 8 a.m. In addition to the nursing director there are six staff nurses, and 29 aides and orderlies.

The staff nurse supervises aides and orderlies on her shift, has direct supervision of the general health program, and assumes complete charge of the children when they are not in school or therapies. She supervises dressing, undressing, and personal care, giving direct attention to nails, ears, noses, scalps, and skin. She also supervises rest periods and eating, carrying out the dietitian's recommendations as to meals and nourishments. Medical supervision is given by the director, R. R. Rembolt, M.D., and a pediatrician from University Hospital is on call at all times.

Nurses at the Hospital School have a much broader type of activity to supervise. The children aren't sick and confined to a bed—they have energy and drive to be doing things. In addition to trips outside the Hospital-School that they make with their Big Sisters or Big Brothers, we arrange for them to go swimming, and to attend shows, university basketball games, all-day picnics in spring, and such special events as the university Homecoming parade. Campus fraternities and sororities also have parties at their houses for the children about once a month.

Supervision of lay people, aides and orderlies who are not familiar with the children's physical problems, is another of our duties. Many aides and orderlies are young enough to be a Big Sister or Big Brother in the child's eyes. They don't have very much authority if the child balks in going to therapy. They have to learn ways of handling the children and getting their cooperation.

Mary Ann, victim of cerebral palsy, is obviously delighted at the thought of the present her "Big Sister," a university student, is about to give her.

NONPROFESSIONAL HELP

We work with a large percentage of nonprofessional nurses. It is the responsibility of the professional nurse to teach these people aspects of care important to the physically handicapped child. We work with them until we feel sure that they have enough judgment to know when something is beyond their ability, and when to turn to a professional. If a child is irritable and upset, it may be because he had a difficult time in school, or he may be acutely ill. It is up to the professional nurse to discern what the trouble is.

For aides and orderlies, we seek people with special preparation and interest in children. We orient them to the physical situation, without going into a great deal of background detail at first. They work with a person in responsibility until they are familiar with the children and with their jobs. Their main purpose is to aid in satisfying the emotional needs of the children through affectionate care and attention, as well as to help the children with activities of daily living.

We have a student nurse educational program which lasts one week. The student nurses encounter problems in learning how to put on braces, dressing and undressing the children, etc., that they do not encounter in their practical experience in the university general hospital. We have between two and four student nurses here at a time.

PERSONAL ASPECT OF CARE

Some of the nurses become mother-figures to the children, who will greet a favorite nurse with a hug and kiss. We don't try to plan this, because it wouldn't work if it were planned.

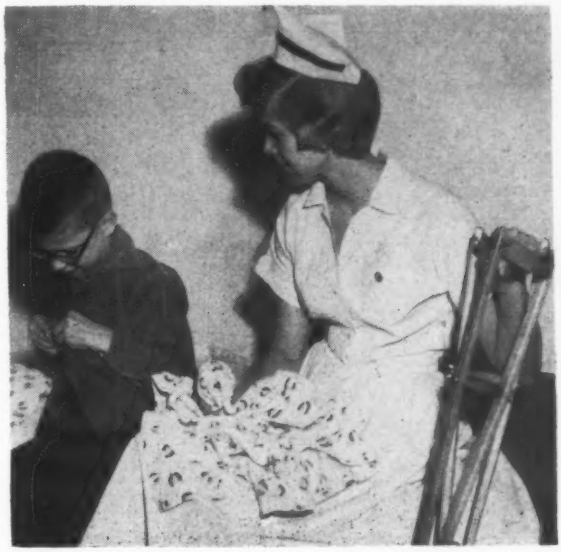
We find ourselves answering questions of a personal nature, often having to do with boy-girl relationships. It is not uncommon for the older boys and girls to have one or more "sweethearts." One 11-year-old boy asked us, "How long do you have to go with a girl before she has a baby?" A girl of the same age demanded a ring from her boyfriend, was displeased with the one he finally gave her, and proceeded to buy herself a dime-store "diamond" for her third finger, left hand. (She told people this ring was from her boyfriend, but whenever he was within earshot, he vehemently denied it.

Because we are a group of persons substituting for home rule in the general care of the child, this personal aspect of care is emphasized in everything from teaching manners to helping the children make a normal adjustment with the opposite sex. However, we don't want to become complete substitutes for their families. We feel that it is important to know each child's home life and refer to it often so he knows that home is the basic unit of living. We want the children to think of their stay in the Hospital School as a temporary way of life.

There is a close interrelationship between nursing and therapy. We need to know what the child is capable of doing, and then see that he does it. It is important to talk with the child to stimulate his desire to talk. Locomotion, use of hands, communication, are all carry-overs from therapy. For instance, we believe in getting children out of their wheel chairs and into regular chairs in the dining room.

Something comparatively new at the Hospital School is a form of student government. The children elect council members who meet with the director and staff members to present problems that they find, and who carry back problems that they think the children ought to solve. The council helps arrange welcomes for parents' visits, and plans improvement assemblies. This gives the children an opportunity to do something for the school, and not just a chance to air their gripes.

Below: Lou Ann Weber, R.N., holds Eric's pajamas while he starts to undress himself at bedtime. Nurses know what each child is capable of doing for himself, and see that he performs these tasks daily.



We try to have as permissive an environment as is healthy for the child, and do not allow spanking. There are few rigid rules. Because the ratio of staff members or adults to children is comparatively large, we can afford to be less rigid. There is approximately one adult to each child, although not all are on duty at the same time. There is, of course, the problem of getting the children to do what they must do. We try to put ourselves in the child's place, and give him a free but limited choice, seeking solutions satisfactory to him. We find that his reward is our approval. When it comes to doing chores, the children are so willing and eager that we don't have enough chores to go around.

(Continued on next page)

Barbara Ketchum, aide, serves mid-afternoon milk and cookies to a kindergarten group. All children receive milk or juice in morning and afternoon.

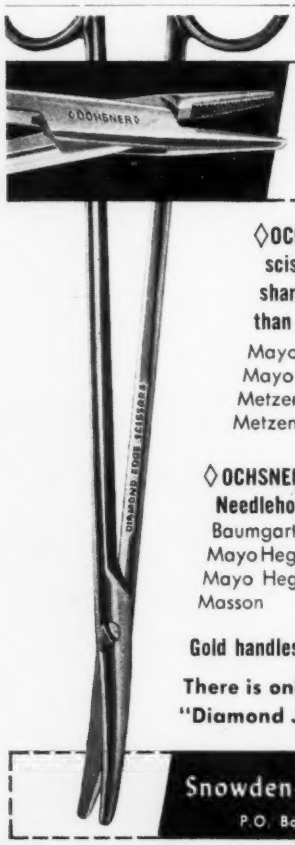
Varied expressions are registered on the faces of children waiting for everyone to reach the dining room for supper.

PEDIATRICS continued

We must cope with the personality differences arising out of the children's handicaps. There are rheumatoid arthritics who have flare-ups, and the cerebral palsied who are healthy but can't do everything. The well children need special help because of their handicap or disability. We find that they learn tolerance of others, and understand that children with different handicaps will be handled differently.

A child will speak of another's handicap very matter-of-factly, saying that Judy will never be able to walk, or that Billy will never be able to feed himself. This is said without a trace of pity, as each child accepts his playmates as they are.

Because of their handicaps, they have a hard time learning to grow up and become independent adults. Some of the children will not achieve independence, but we try to help them achieve a normal, happy life even if they will not be able to walk or talk normally. We teach them to live with what they cannot change.



WANT THE finest?

◊OCHSNER◊ Diamond Edge scissors maintain razor edge sharpness 100 times longer than conventional scissors

Mayo str.	5½"	14.25
Mayo str.	6¾"	14.50
Metzenbaum	5¾"	15.30
Metzenbaum	7"	15.30

◊OCHSNER◊ Diamond Jaw Needleholders.

Baumgartner	5"	15.75
Mayo Hegar	6" or 7"	15.75
Mayo Hegar	8"	17.25
Masson	10"	18.50

Gold handles for identification

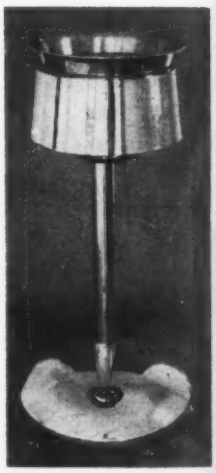
There is only one "Diamond Jaw" Needleholder!

Snowden-Pencer Corporation
P.O. Box 186, Los Gatos, Calif.

EXPLOSION-PROOF ★ THERMOSTAT CONTROL

STERILE SOLUTION WARMER

The only explosion-proof surgical heating unit of its kind. Proven throughout the nation as a low cost multi-purpose piece of equipment designed to save time and effort in operating rooms and wards alike. Once the basin containing the heated sterile solution is placed in its receptacle, the warmer's heating element maintains constant temperature until the basin is removed.



This leaves the circulating nurse to be more efficiently utilized in other phases of the operation.

Adjustable thermostat control keeps solution at fixed temperature indefinitely.

Approved by Underwriters' Laboratories for explosive atmospheres

THE Lin COMPANY P. O. BOX 247 CLINTON, OKLA.

Cheerful Surroundings Reduce Fears of EEG

Pictures on the wall, colorful drapes, toys, and an FM radio help reduce fears, both in the child and the parent, at the electroencephalography room at Children's Hospital, Washington, D.C.

Children are prepared in advance for the test. The small child is given a bottle, and by the time the test is ready to be run, he is fast asleep. Boys are told that they are going on an extended trip to outer space. A mirror is given to the girls so that they can pretend they are in a big beauty parlor. Each child receives a lollipop.

For the child with severe mental retardation, or other forms of mental illness, sometimes an intravenous sedation is given, and arrangements are made for the tot to stay at the hospital overnight.

The laboratory opened in April of 1953. Approximately 800 records per year are run.

The machine has its greatest usefulness in diagnosis of convulsive disorders. On several occasions, it has been of assistance to adoption agencies when the question of inheritable epilepsy was raised about infants being considered for adoption.

Above: Part of the head section of a regular bed has been cut out to make it easier for the technician to obtain an accurate reading.

Below: The patient rests, with his eyes closed, as his brain waves are recorded in a continuous tracing by the electroencephalograph. Side rail was lowered to take the picture, but normally would be up in position, to protect the patient.

Now everybody's talking...

about... *closer control of cross infection in every part of the hospital*

Wider recognition of the current problem of hospital-acquired infections is focusing new attention on ways and means of reducing this hazard to good patient care. Hospital and medical society meetings—and hospital, medical and surgical journals—are daily shedding new light on the varied aspects of the overall problem.

In many hospitals, a special "committee on cross infection" has been appointed to review practices and procedures. In others, each department head is studying closely his or her own methods of operation. Few hospitals exist which are not giving some special thought to this highly current problem.

Out of this critical evaluation has grown an awareness that environmental asepsis is a major weapon for cutting cross infection to a minimum. Application of continuous disinfection procedures from operating rooms through food service and laundry areas can be the means to changing the hospital's entire experience with hospital-acquired respiratory, intestinal, urinary or post-operative wound infections.

Take floors, for instance

Floors offer a great opportunity for furthering the spread of infection. Microorganisms settling to the floor are redispersed on dust particles or tracked through the hospital on shoes. Walls and ceilings as well can be reservoirs of potential infection. Lehn & Fink disinfectants not only kill all the most common pathogens on contact but are continuously active against new contaminants touching the disinfected surface for as long as a week later.

While the patient is there

Concurrent disinfection is practical whether or not the patient is "isolated." Wiping of furniture and fixtures and damp mopping of floor, with a disinfectant, stop air- and floor-borne microbes at the source.

In the operating room

Lehn & Fink disinfectants have many applications here. Among them: mopping floors; cleaning grills, ducts, and coils of air conditioners; as standard equipment on the scrub-up cart; as a germicidal dip to remove gross contamination from gloves before their removal; to gather instruments into enroute to sterilizer.

Other L & F disinfectant applications are many: for disinfection of instruments with lens systems, to wipe and store thermometers, to sanitize utensils, etc. In all instances, action is bactericidal, fungicidal and tuberculocidal.

Which L & F disinfectant?

Lysol®, O-syl® and Amphyl® do the same disinfecting job. Any one of them kills bacteria, fungi, and TB bacilli efficiently, but each has individual characteristics.

Lysol was far ahead of its time when introduced over sixty years ago. Recently the formula was improved; the odor was lightened and toxicity was reduced so that the "poison" label is no longer needed. Many hospitals prefer Lysol because of its long reputation for dependability. The characteristic odor is preferred by many for psychological reasons or as an indication that disinfection with Lysol has just been done.

O-syl is preferred by hospitals wanting all the germicidal efficiency of Lysol but without the odor. It is practically odorless when diluted for use. Like Lysol, O-syl is highly concentrated. Only a 1% solution of either (1 part to 100 of water) is needed for most applications.

Amphyl is also odorless when diluted for use. Convenience and low cost due to its high concentration often make Amphyl the disinfectant of choice. Amphyl is twice as powerful as Lysol or O-syl but does not cost twice as much. A ½% solution (1 part in 200 of water) is sufficient for general disinfection so that the cost per gallon of "use dilution" is less than with Lysol or O-syl. When expected contamination is great, as in TB or isolation wards, Amphyl is often preferred.

Let's talk about it

Solving the problem of environmental infection has been the business of Lehn & Fink since 1874. Solving such problems arising in your own hospital usually takes more than talk—but perhaps you would like to discuss them with our technical specialists. We can function as a part of your "committee on control of cross infection," perhaps suggest procedures, and supply informational material for teaching purposes. At any rate, please ask us. Specially trained field service representatives as well as the technical staffs in our New York office and in our laboratories at Bloomfield, New Jersey, are available for consultation.

• • •

Lehn & Fink disinfectants are available through your surgical supply dealer.

If you want literature, samples, or assistance in setting up procedures, please write:

Lehn & Fink PRODUCTS CORPORATION *Professional* DIVISION
445 PARK AVENUE, NEW YORK 22, N.Y.

SPECIALISTS IN ENVIRONMENTAL ASEPSIS
®T.M. REG.

luted
due
nake
oice.
Lysol
nuch.
ater)
on so
tion"
When
as in
often

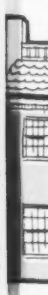
ental
Lehn
prob-
sually
s you
tech-
as a
rol of
proce-
terial
olease
ervice
nical
in our
ersey,

ailable

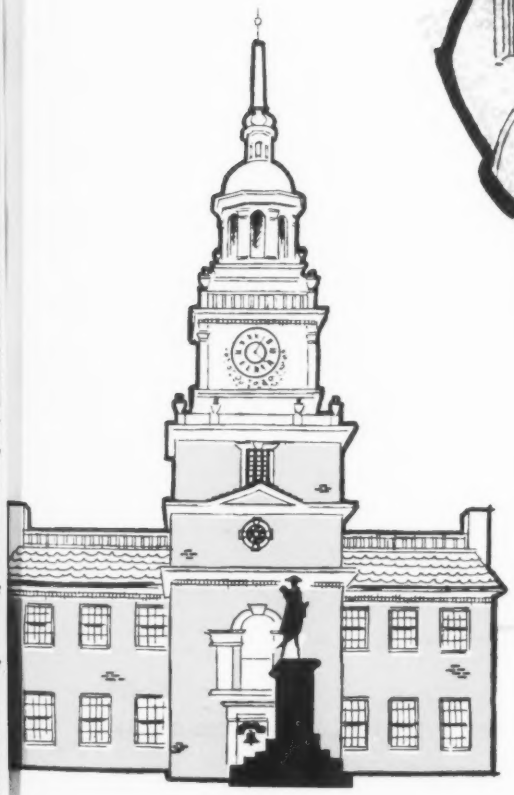
istance
:

onal
ON
2, N.Y.
SEPSIS
T.M. REG.
OPICS

H
to
C



How is THEE getting to the A.O.R.N. Conference?



Philadelphia, Pennsylvania
February 10-12, 1958

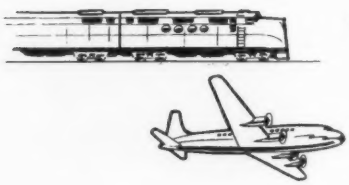
One nurse is going . w

It could be YOU!

Enter the Johnson & Johnson A.

You May Win FOR YOURSELF

ROUND-TRIP TRANSPORTATION



to Philadelphia -- by train or plane as you prefer!

HOTEL ACCOMMODATIONS

for all convention days at the elegant Bellevue-Stratford!

ON-THE-TOWN in your free time -- go where you choose -- as the guest of Johnson & Johnson.

- **Broadway-bound theater**
- **historic centers**
- **symphonies and concerts**
- **world-renowned restaurants**
- **museums and art galleries**

. with all expenses paid .

A.O.R.N. Convention Contest

You May Win
FOR YOUR HOSPITAL

A 3-Year Nursing Education Scholarship ($500.00).

This scholarship, in your name, will be presented by Johnson & Johnson to your Directress of Nurses for scholarship aid to a student nurse of your hospital's selection.

Your hospital need not offer a formal training program in order to qualify for the scholarship — the funds may be used for student aid at any recognized institution offering the R.N. degree.

A BRONZE PLAQUE --

also in **your** name
-- permanently
commemorating
the scholarship grant
to your hospital.

Here's all you have to do to win!

In 100 words or less . . .

Suggest ways to attract more girls into the career of nursing.

If your entry is judged best, you'll go to Philadelphia and the 5th National Conference of the A.O.R.N. as the all-expense guest of Johnson & Johnson.

Enter this easy contest . . . this year, YOU be the winner!

CONTEST RULES

1. Entries will be judged primarily on the basis of originality and practicality. Sincerity, neatness and aptness of expression will also count.
2. Participant must be a registered nurse with at least six months' experience in surgery.
3. You may submit as many entries as you wish.
4. Send your entries to: A.O.R.N. Contest, Johnson & Johnson, New Brunswick, N. J. Contest closes November 30, 1957.
5. All entries must be on official contest forms. These may be obtained from your J&J representative, or by writing to A.O.R.N. Contest, Johnson & Johnson, New Brunswick, N. J.
6. All entries become the property of Johnson & Johnson.
7. Johnson & Johnson will be the sole judge of the contest winner.
8. In case of duplicate entries, only the one bearing the earliest postmark will be considered.

1957 WINNER

Sister
Catherine Davenport,
O.R.S.
St. Joseph's Hospital
Pittsburgh, Pa.

1956 WINNER

Miss
Mary Ellen Riley,
R.N.
Sisters of Charity
Hospital
Buffalo, N. Y.

Johnson & Johnson

© J&J 1957

Texas Association's Vice-President Resigns

Sister M. Annella has resigned as vice-president, Texas Hospital Association, in order to complete her master's degree in hospital administration at St. Louis University. Administrator of St. Ann Hospital, Abilene, for the last six years, she expects to finish her studies next June and complete a one-year preceptorship before returning to Texas.

Bill Burton

Bill Burton, administrator, Southwestern General Hospital, El Paso, and a member, THA board of trustees, will fill her unexpired term.

Sister Mary Vincent, administrator, St. Joseph's Hospital, Ft. Worth, was elected to fill Mr. Burton's term.

Smiley Named Head of New AMA Council

Dean F. Smiley, M.D., who has been serving as secretary, Association of American Medical Colleges, will become director of the American Medical Association's newly-formed educational council for foreign medical graduates.

The council's chief function will be to evaluate individual foreign medical school graduates and supply resulting information to state boards, hospitals, and other agencies on request. It will also assume the responsibility of furthering a student's medical education in this country if he has the right background and can benefit from it.

VA Psychologists Rate Mental Illness Symptoms

Psychologists and psychiatrists at 12 VA neuropsychiatric hospitals have designed and successfully tested a form on which mental illness symptoms can be rated accurately through interviews with patients.

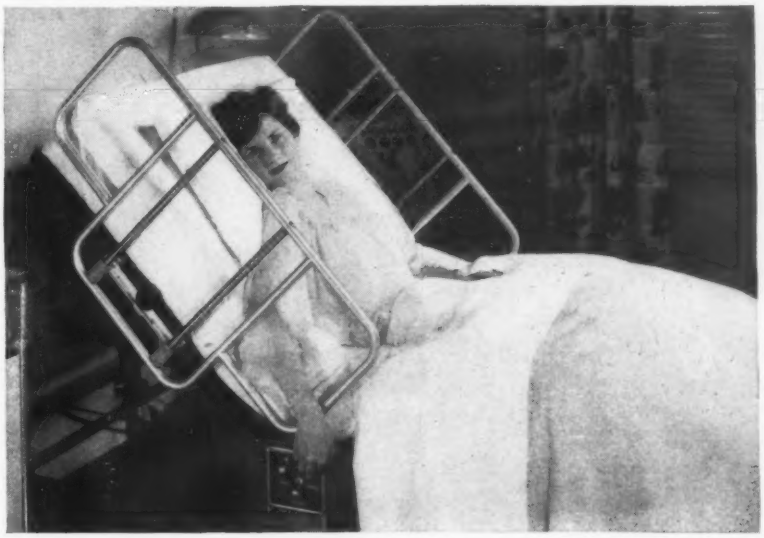
Nearly 2,000 patients admitted for severe mental illness (primarily schizophrenia) were interviewed by the psychologists, who recorded degree or absence of symptoms such as withdrawal, anxiety, and disorganization of thinking.

The same group is being interviewed and rated again. Two rechecks will be made, one at six months and the other a year after the original interview.

any height . . . any spring position

at the touch of a button . . .

by either patient or nurse



with the all-electric "PUSH-BUTTON" Hilow Bed

by Hill-Rom

● This new Hill-Rom Hilow Bed is designed so that operation of the hilow feature and adjustment of the backrest and knee rest may be handled by either patient or nurse. Push button controls for patient use are located on the patient's right—in the seat section of the spring. For the patient who must remain in a certain prescribed position, the bed may be placed in that position and the patient control switches then rendered inoperative. All switches are mechanically interlocked—no two push buttons can be operated at the same time.

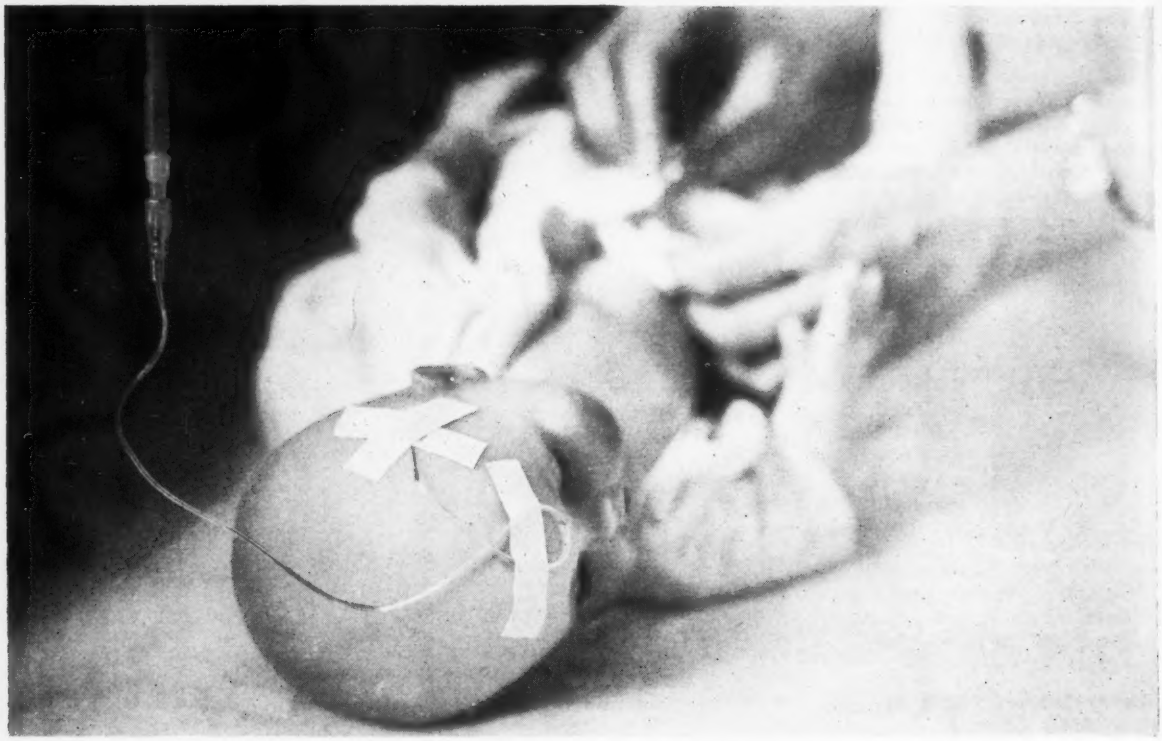
Maximum convenience for the nurse, maximum comfort and safety for the patient

This modern, safe and efficient hilow bed can be maintained at the "low" position at all times to insure maximum safety. Much time will be saved the nurse by elimination of unnecessary trips to the patient room or unit. The patient has access to head and knee rest and does not need the nurse for routine adjustment of the spring.

Head end and foot end panels, designed by Raymond Loewy, add to the appearance and function of the bed. For complete information on this or any of the three other Hill-Rom Hilow Beds, write for Procedure Manual No. 3.

HILL-ROM COMPANY, INC. • Batesville, Indiana

Now ready . . . **Procedure Manual No. 3—"Hilow Beds"** by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom, and author of three leading textbooks on nursing, also P.M. No. 1, "Safety Sides—A New Safety Measure" and P.M. No. 2, "The Recovery Bed, Labor Bed, Special Therapy Bed." Copies of any of these manuals for student nurses and graduate nurse staff will be sent on request. Address: Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Indiana.



Easier... *to use – easier on the patient*

PEDIATRIC SCALP VEIN INFUSION SET / CUTTER

This disposable scalp vein set offers greater convenience and greater safety in pediatric I. V. therapy. Soft, highly flexible tubing allows easy coiling and taping to the scalp, eliminating head restraints and minimizing nursing care. Its specially designed needle reduces tissue damage and cut-downs are rarely required. Each set consists of: plastic adapter for easy attachment to conventional I. V. set, 12 inches of soft, pliable tubing, short-beveled, small gauge needle in protective sheath. Pyrogen-free, sterile inside and out, it is packed in a polyethylene envelope.

CUTTER SAFTILINE* EXTRAS

choose the complete line of expendable I. V. infusion sets with extra features for safety and convenience.

Saftiset "Streamliner"* expendable, plastic I. V. infusion set available with or without needles.

Saftiset "Y"* expendable, plastic I. V. infusion Y-tube set for simultaneous infusion of two solutions.

Safticlysis* expendable hypodermoclysis injection set available with or without needles.

* *For descriptive literature, write Dept. 44-K*

ask your Cutter man *for more detailed information*

60th *fine pharmaceuticals for 60 years*

CUTTER LABORATORIES

BERKELEY, CALIFORNIA

HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

Planning the New 'Philadelphia Story'

Throughout the summer vacation period, Philadelphia operating room nurses have been working diligently on plans for the fifth national Congress, Association of Operating Room Nurses, to be held February 10-13, 1958, at the Bellevue-Stratford Hotel, Philadelphia.

Pictured above at one meeting of committee chairmen are (l. to r.): Mrs. Vernita Cantlin, R.N., chairman, advance registration committee; Helen Steele, O.R.S., Northeastern Hospital, and chairman, hospitality committee; Bea Hunsberger, O.R.S., Methodist Hospital, and chairman, entertainment committee; Mrs. Isabelle Barr, O.R.S., VA Hospital, Wilmington, Del., and chairman, program committee; Pauline Young, O.R.S., Hahnemann Medical College and Hospital, national president, Association of Operating Room Nurses, and general chairman for the 1958 congress; Betty Hagen, clinical instructor in the operating room, Episcopal Hospital, and chairman, scientific exhibits, and Elizabeth McAleese, O.R.S., VA Hospital, Philadelphia, and chairman, publicity committee.

For the first information on program plans, please see pages 108 and 109. →

Nationally-Known Surgeons Named as AORN Speakers

Nationally-prominent surgeons from the Philadelphia area will be among the speakers at the fifth national congress of the Association of Operating Room Nurses.

The congress will be held February 10-13, 1958, at the Bellevue-Stratford Hotel, Philadelphia.

Opening address will be given by Isador S. Ravdin, M.D., John Rhea Barton professor of surgery, University of Pennsylvania School of Medicine, and chairman, board of regents, American College of Surgeons.

Other Philadelphians so far scheduled include:

John D. Reese, clinical professor of plastic and reconstructive surgery, Jefferson Medical College, "Plastic Surgery with the Aid of Skin Graft."

Robert D. Dripps, Jr., M.D., professor of anesthesiology, University of Pennsylvania School of Medicine, "Recovery Rooms."

Lewis W. Bluemle, Jr., M.D., urologist, University of Pennsylvania Hospital, "The Artificial Kidney."

Charles P. Bailey, M.D., professor of thoracic surgery, Hahnemann Medical College and Hospital, who will speak on cardiovascular surgery.

Chevalier L. Jackson, M.D., professor of laryngology and broncho-esophagology, Temple University School of Medicine.

Eugene B. Spitz, M.D., assistant professor of pediatric neurosurgery, University of Pennsylvania School of Medicine.

Besides individual lectures by these physicians, sessions have been scheduled so far on the following subjects:

"Working with the Nurse in Planning and Designing the New Operating Room," to be presented by John G. Steinle, Garden City, N.Y., hospital consultant, and a panel including a hospital architect, an engineer, and an operating room nurse.

"Over-Use and Abuse of Antibiotics," a panel discussion to be presented by H. Taylor Caswell, M.D., clinical professor of surgery, Temple University School of Medicine, Philadelphia, and a committee from Temple University Hospital.

A forum discussion on sterilization, to be coordinated by John C. Gabel, Wilmot Castle Co. Two of the participants will be Velma L. Chandler, Ph.D., and Earle H. Spaulding, Ph.D., both microbiologists.

"Improving Work Relationships Through Communication, Leadership, and Human Understanding."

"Changing Patterns in Operating Room Staffing," which will cover the role of the nonprofessional worker in the O.R. and will include teaching outlines for inservice training.

"How to Institute Good Housekeeping in the Operating Room."

"Dealing with Radium and Radioisotopes in the Operating Room." This lecture is expected to include precautionary measures necessary for operating-room personnel in handling, transporting, and storing radium, and in working with radioactive elements and with fluoroscopes and x-ray machines in the surgical suite.

Plans call for dividing the always-popular "problem clinic" into two sessions this year: one for small hospitals and one for average and large hospitals.

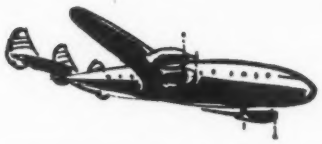
Carefully selected scientific and technical exhibits will be on display, covering a wide variety of subjects.

The fourth day of the meeting, following the conclusion of the three days of formal sessions and exhibits, will be devoted to hospital clinics at some of the leading institutions in Philadelphia.

Start planning now to attend the fifth AORN congress. This meeting provides an excellent opportunity for obtaining the latest information on developments in your field, and for finding solutions to your specific problems.

Further details on program topics and participants will be announced in the next issue of HOSPITAL TOPICS.

Pauline Young, R.N., President
Edith Dee Hall, R.N.,
Manager of Annual Congress
Association of Operating Room Nurses



AIRLINE FARES TO PHILADELPHIA

For those whose time is limited and who wish to get to and from the meeting as rapidly as possible, American Airlines has prepared a list of the lowest round-trip fares available from the following major cities:

From	Total Fare (Inc. Tax)	Service
Albuquerque	$182.60	Aircoach
Atlanta	69.52	Day Coach
Birmingham	82.72	Day Coach
Boston	30.40	Aircoach
Buffalo	45.00	First Class
Butte, Mont.	228.25	First Class
Chicago	68.20	Aircoach
Cincinnati	56.80	Aircoach
Cleveland	29.70	Night Coach
Dallas/Fort Worth	133.55	Aircoach
Denver	158.40	Aircoach
Detroit	48.40	Aircoach
El Paso	192.30	Aircoach
Houston	147.20	Day Coach
Kansas City	107.80	Aircoach
Los Angeles	215.60	Aircoach
Miami	95.15	Night Coach
	110.22	Day Coach
Minneapolis	92.40	Night Coach
Nashville	78.32	Aircoach
New Orleans	117.04	Aircoach
Pittsburgh	28.40	Aircoach
Portland	215.60	Aircoach
St. Louis	85.50	Aircoach
Salt Lake City	198.00	Aircoach
San Francisco	215.60	Aircoach
Seattle	215.60	Aircoach
Tucson	207.40	Aircoach

NATIONAL AORN BYLAWS AVAILABLE

Anyone who has not received a copy of the national bylaws of the Association of Operating Room Nurses may obtain one or more copies by writing to the association's headquarters at 305 W. 18th St., New York 11, N. Y.

TECHNICAL EXHIBITORS

On hand to answer your questions and to help solve your problems on maintenance and operation will be well-trained representatives of firms which have been specially invited because their products are of interest to the operating room staff. So far, the following companies are scheduled to have exhibits:

Abbott Laboratories
Acme Cotton Products Co., Inc.
Aeroplast Corp.
Aetna Scientific Co.
A. S. Aloe Co.
American Cyanamid Co.
(Surgical Products Division)
American Cystoscope Makers, Inc.
American Hospital Supply Corp.
A.S.R. Products Corp.
American Sterilizer Co.
Anchor Products Co.
Aseptic-Thermo Indicator Co.
Austenal, Inc.
C. R. Bard, Inc.
Bard-Parker Co., Inc.
Bauer & Black
Rudolph Beaver Co
Becton, Dickinson and Co.
S. Blickman, Inc.
John Bunn Corp.
Wilmot Castle Co.
Chesebrough-Pond's, Inc.
Gilbert Hyde Chick Co.
Clay-Adams, Inc.
The Coca-Cola Co.
Conductive Shoe Co.
Connecticut Bandage Mills, Inc.
Cutter Laboratories
Davol Rubber Co.
J. A. Deknatel & Son, Inc.
DePuy Mfg. Co., Inc.
Dittmar & Penn Corp.
Doho Chemical Corp.
Duke Laboratories, Inc.
Eisele & Co.
Ethicon, Inc.
The Fengel Corp.
Fenwal Laboratories, Inc.
B. F. Goodrich Co.
(Industrial Products Division)
Gudebrod Bros. Silk Co., Inc.
Gomco Surgical Mfg. Corp.
Harold Supply Corp.
Hausted Mfg. Co.
Hoffmann-La Roche, Inc.
Franklin C. Hollister Co.
Hollywood Turban Products Co.
Homer Higgs Associates, Inc.
Huntington Laboratories, Inc.
Dr. Stephen Jackson
Johnson & Johnson
The Lawton Co.
Lehn & Fink Products Corp.
Liebel-Flarsheim Co.
The Lin Co.
The MacBick Co.
MacGregor Instrument Co.
Maico Co., Inc.
Marsales Co., Inc.
Mead Johnson & Co.
Medical Fabrics Co., Inc.
Meinecke & Co., Inc.
E. Miltenberg, Inc.
V. Mueller & Co.
Ohio Chemical & Surgical
Equipment Co.
Orthopedic Frame Co.
O.R. Products Co.
Parke, Davis & Co.
Pharmaseal Laboratories
The Pioneer Rubber Co.
George P. Pilling & Son Co.
Pratt Hospital Equipment Mfg. Co.
Professional Tape Co., Inc.
Randall Faichney Corp.
Richards Mfg. Co.
Ritter Co., Inc.
Will Ross, Inc.
Ruby Products Co., Inc.
Sanders and Co.
Dennis R. Scanlan, Inc.
Charles A. Schmidt Surgical
Instrument Co.
The Scholl Mfg. Co., Inc.
The Seamless Rubber Co.
Shampaine Co.
J. Sklar Mfg. Co.
Smith and Underwood
Snowden-Pencer Corp.
E. R. Squibb & Sons
Storz Instrument Co.
The Torrington Co.
Travenol Labs., Inc.
(Subsidiary of Baxter Labs., Inc.)
United Surgical Supplies Co.
Vestal, Inc.
Edward Weck and Co., Inc.
Winthrop Laboratories, Inc.
The Max Wocher & Son Co.
Zimmer Mfg. Co.

Ethylene-Oxide Sterilization in Ophthalmology*

By R. A. Skeehan, Jr., Lt. Col. (MC),

J. H. King, Jr., M.D., and Saul Kaye, A.B.**

Sterilization of ophthalmic instruments and equipment is a major concern in the daily practice of ophthalmology. For sharp instruments, various solutions such as benzalkonium chloride and Bard-Parker Formaldehyde Germicide solution have been utilized. Other instruments are autoclaved or subjected to high-pressure steam in order to be rendered sterile. Ultraviolet irradiation of various instruments is of questionable efficacy.

Rendering sterile an entire hand slitlamp, a metal locator probe (Berman) and cord, a giantscope, or an ophthalmoscope by heat or soaking would certainly damage or destroy these items. An ideal sterilizing agent for such items would be a noncorrosive and nondamaging gas which would diffuse through all types of porous substances, which could easily be removed by simple aeration following treatment, and which could effectively destroy all forms of micro-organisms at ordinary temperatures. In addition, other desirable features would include rapid action, low toxicity to human beings, non-inflammability, ease of handling and storage, and ready availability.[1]

When the sterilizing properties and desirable characteristics of gaseous ethylene oxide became known, studies were begun to determine if there was a practical method of employing this type of sterilization in ophthalmologic practice.

Ethylene oxide (also known as 1, 2-epoxyethane and oxirane) is the simplest of the epoxy compounds, which are molecules containing two carbon atoms and an oxygen atom linked together in a three-membered ring. Such compounds are very reactive.

The chemical structure of ethylene oxide is

$$CH_2 - CH_2.$$
$$\backslash\ /$$
$$O$$

Ethylene oxide has a specific gravity of 0.8838 10/4 C. It boils at 10.8° C., and freezes at —111.3° C. It is a gas at ordinary temperatures and pressures, but is easily liquefied. It is soluble in all proportions in water, alcohol, and ether. The gas has a rather pleasant ethereal odor. It is highly flammable, and the vapors form an explosive mixture with air in all proportions from three to 100 percent by volume.

This explosive danger is eliminated, however, when the gas is mixed with more than 7.15 times its volume of carbon dioxide. A commercial product is manufactured (Carboxide®)† consisting of 10% ethylene oxide and 90% carbon dioxide. This combination can be mixed with air in any proportion without forming an explosive mixture.

Carboxide is available in large gas cylinders containing either 30 or 60 pounds of gas under about 800 pounds per square inch pressure. Use of this mixture in a sterilizing chamber requires an expansion chamber to avoid fractionation of the mixture and to reduce the pressure to about 80 pounds per square inch, after which it can be admitted to the sterilizer.‡

It is possible to admit short bursts of Carboxide directly into the sterilizer, but control is difficult, the valves may freeze, and the proportions of carbon dioxide and ethylene oxide are not uniform (Fig. 1). For the purposes for which this gas was to be used in ophthalmology, such an apparatus would be too bulky and expensive.

It was found that the Army Chemical Corps was using a new and more convenient method of gaseous ethylene oxide sterilization. The ethylene oxide was mixed with dichlorodifluoromethane (Freon-12) instead of with carbon dioxide, there being 18.75% ethylene oxide and 81.25% dichlorodifluoromethane in a 12-ounce sealed can under about 55 pounds per square inch pressure. The can thus contains about 75 cc. of ethylene oxide in the liquid state.§

The contents of the can are easily admitted to the sterilizer by means of a needle valve*** to which the can is screwed, top down, to permit flow of all liquid into the inlet port. The liquid mixture immediately expands to a gaseous form on entering the tubing to

*Reprinted with permission from the *Am. J. Ophth.* 42:424-30 (September, 1956). The article was from the ophthalmology service, Walter Reed Army Hospital, and the ocular research unit, Walter Reed Army Medical Center, Washington, D.C.

**At the time the article was published, Lt. Col. Skeehan was at the ophthalmology service, Walter Reed Army Hospital; Dr. King was chief, ophthalmology, Washington Clinic, and clinical associate professor of ophthalmology, Georgetown University Medical School; and Mr. Kaye was with the U.S. Army Chemical Corps, Camp Detrick, Md.

†Carboxide, product of Carbide and Carbon Chemicals Corporation, Passaic, New Jersey.

‡American Sterilizer Co., Erie, Pa.

§Can-O-Gas valve manufactured by the Virginia Smelting Co., West Norfolk, Va.

***These cans are available from American Sterilizer Co. under the name of "Cry-Oxcide."

Fig. 1 Carboxide sterilizing apparatus.

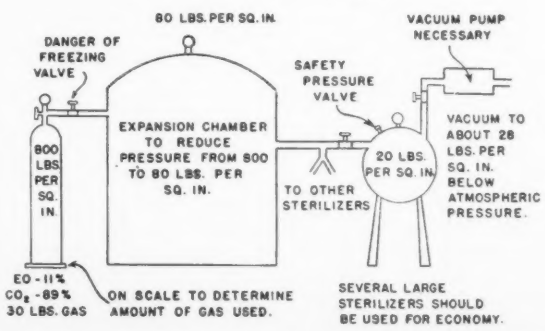
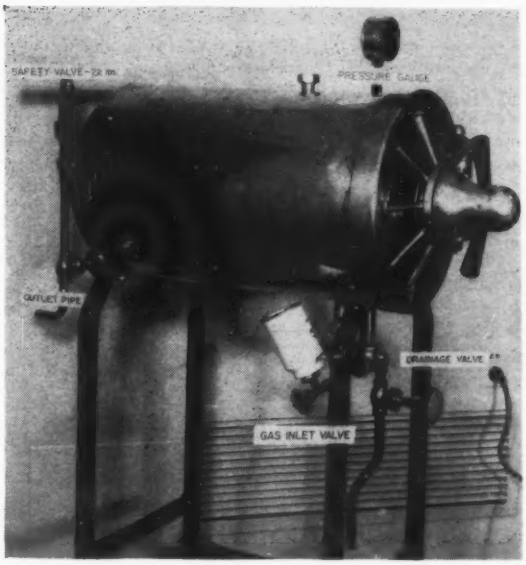

80 LBS. PER SQ. IN.
VACUUM PUMP NECESSARY
DANGER OF FREEZING VALVE
SAFETY PRESSURE VALVE
EXPANSION CHAMBER TO REDUCE PRESSURE FROM 800 TO 80 LBS. PER SQ. IN.
800 LBS. PER SQ. IN.
20 LBS. PER SQ. IN.
VACUUM TO ABOUT 28 LBS. PER SQ. IN. BELOW ATMOSPHERIC PRESSURE.
TO OTHER STERILIZERS
EO - 11% CO2 - 89% 30 LBS. GAS
ON SCALE TO DETERMINE AMOUNT OF GAS USED.
SEVERAL LARGE STERILIZERS SHOULD BE USED FOR ECONOMY.

Fig. 2 Modified steam sterilizer.



the inlet port of the sterilizing chamber. No previous exhaustion of air is necessary.

An old or discarded small steam sterilizer can be easily modified so that the vapor enters through the former condensate return line (Fig. 2). A short length of pipe with a valve is also fixed to the entrance port. The former steam inlet line is fitted with a pipe and valve for exhaust. A safety valve adjusted to 22 pounds per square inch, and a pressure gauge for measuring positive and negative pressures, complete the attachments to the sterilizer (Fig. 3).

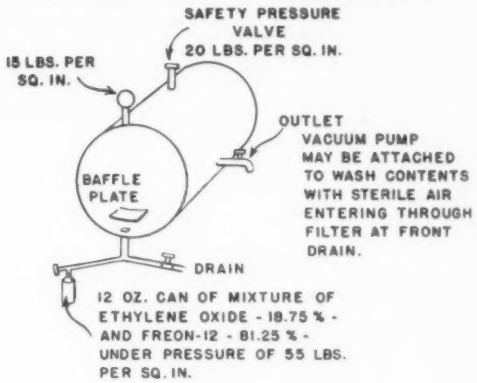
A vacuum pump can be used on the rear outlet pipe to wash the contents of the chamber with sterile air admitted through a filter attached to the side pipe of the entrance port. However, it has not been found necessary to aerate the materials which have been sterilized. Instruments are double-wrapped in linen, and about 30 minutes' exposure to room atmosphere suffices to rid the materials of all discernible traces of ethylene oxide. There is no difficulty in maintaining proper concentration of ethylene oxide, since the entire contents of the can are used during each run.

PROCEDURE

The experiments were performed at room temperature and at relative humidities of from 20 to 35 percent. Moisture is necessary for ethylene oxide to exert its sterilizing action.[2] The pressure within the chamber rises to about 22 pounds per square inch. After a period of 12 hours, the pressure has dropped to about 10 pounds per square inch, indicating that the gas slowly escapes even from a well sealed chamber. Experiments were conducted using *Pseudomonas aeuginosa*, a very common contaminant, and spores of *Bacillus globigii*. The latter are among the most resistant micro-organisms known. Six-hour exposures were carried out at first.

Controls were run simultaneously on contaminated cardboard spatulas, cellophane disposable eyedroppers, and glass and metal not exposed to ethylene oxide vapors. These demonstrated that sufficient organisms survived the six-hour period at normal room temperature and humidity to rule out the possibility of negative cultures due to spontaneous death of all organisms (Tables 1 and 2). The quantity of micro-organisms placed on each test site was equal to or greater than that found after direct contact with a frankly purulent lesion.

Fig. 3 Freon-ethylene oxide sterilizing apparatus.


SAFETY PRESSURE VALVE
20 LBS. PER SQ. IN.
15 LBS. PER SQ. IN.
OUTLET
VACUUM PUMP MAY BE ATTACHED TO WASH CONTENTS WITH STERILE AIR ENTERING THROUGH FILTER AT FRONT DRAIN.
BAFFLE PLATE
DRAIN
12 OZ. CAN OF MIXTURE OF ETHYLENE OXIDE - 18.75 % - AND FREON-12 - 81.25 % - UNDER PRESSURE OF 55 LBS. PER SQ. IN.

Relatively inaccessible areas on various ophthalmic instruments were chosen as test sites for contamination by *Bacillus globigii* and *Pseudomonas aeruginosa*. In order to be certain that a significant number of organisms were implanted on each area, a duplicate test site was contaminated in each area and, after drying, sterile swabs were rubbed over these latter sites and the swabs broken off into tubes of sterile nutrient broth. In every case there was growth, thus indicating that the instruments were actually contaminated.

The various items, double-wrapped in Kraft paper, were then exposed to ethylene oxide vapor in the concentration of 1.25 ml. per liter for six hours. At the end of that time each of the original sites was swabbed as above. Tables 3 and 4 show the results of six-hour exposure to ethylene oxide vapor. In no case was there a positive growth on plates or in nutrient broth.

(Continued on next page)

TABLE 1

Death Rate in Six Hours of Ps. Aeruginosa and B. Globigii Spores on Articles Not Exposed to Ethylene Oxide

Type of Article	Immediately after Contamination		Six Hours after Contamination	
	Total *B. globigii* Recovered	Total *Ps.* Recovered	Total *B. globigii* Recovered	Total *Ps.* Recovered
Spatula	7,600	31,500	4,750	35
Eyedropper	1,610	364,000	1,110	2,800

Further studies were made with contaminated cellophane disposable eyedroppers and paper spatulas packed in cardboard boxes. These droppers and spatulas are used routinely in our clinic to apply solutions and ointments to individual eyes and to prevent contamination of various medications as demonstrated by King.[3] Some boxes were sealed in cellophane and some were left unwrapped. In both cases, there was complete sterilization (Table 5).

Many other trials were made in order to double-check the results and to determine the minimum time necessary for complete sterilization at room temperature. *Pseudomonas aeruginosa*, *Bacillus globigii*, and *Bacillus subtilis* were used as test organisms. It was found that exposure to the ethylene oxide-dichlorodifluoromethane mixture for less than two hours and 15 minutes always resulted in incomplete sterilization, but that exposure for three hours always resulted in negative cultures. In most cases, two and a half hours would render the test objects sterile.

Separate investigations had shown that by increasing the temperature of the sterilizing chamber by 10° C. the exposure time was halved. Also, doubling the concentration of the ethylene oxide doubled the effectiveness.

TABLE 2

Death Rate in Six Hours of Ps. Aeruginosa and B. Globigii Spores on Surfaces Not Exposed to Ethylene Oxide

Surface	Immediately after Contamination		Six Hours after Contamination	
	Total *B. globigii* Recovered	Total *Ps.* Recovered	Total *B. globigii* Recovered	Total *Ps.* Recovered
Glass	5,750	1,200,000	7,110	7,000
Metal	2,465	700,000	2,395	1,760

TABLE 3

The Sterilization of Ophthalmic Instruments by Exposure to Ethylene Oxide Vapor: Test Organism B. Globigii Spores

(1.25 ml./liter for six hours)

Instrument	Site	Before Exposure to Ethylene Oxide	After Exposure to Ethylene Oxide
		Total *B. globigii* Recovered	Total *B. globigii* Recovered
Ophthalmoscope	Body	4,200	0
Cautery	Plastic	1,480	0
Scissors	Center	500	0
Loupe	Lens	1,600	0
Magnet	Cord	2,240	0
Magnet	Tip	1,410	0
Locator, Berman	Plastic tip exterior	1,620	0

TABLE 4

The Sterilization of Ophthalmic Instruments by Exposure to Ethylene Oxide Vapor: Test Organism Ps. Aeruginosa

(1.25 ml./liter for six hours)

Instrument	Site	Before Exposure to Ethylene Oxide	After Exposure to Ethylene Oxide
		Total *Ps.* Recovered	Total *Ps.* Recovered
Ophthalmoscope	Body	98,000	0
Cautery	Terminals	790	0
Scalpel	Blade	162,000	0
Tonometer	On shaft, slipping back into base	30,000	0
Loupe	Lens	168,000	0
Magnet	Body	136,000	0
Locator, Berman	Tip, covered by plastic tip	700,000	0

TABLE 5

Sterilization of Articles Contaminated with B. Globigii Spores or Ps. Aeruginosa by Exposure to Ethylene Oxide Vapor

(1.25 ml./liter for six hours)

Type of article	*B. globigii*		*Ps.* aeruginosa	
	Total Organisms Recovered	Nutrient Broth	Total Organisms Recovered	Nutrient Broth
Spatula	0	No growth	0	No growth
Eyedropper in unsealed box	0	No growth	0	No growth
Eyedropper in cellophane-sealed box	0	No growth	0	No growth

In order to provide a wide margin of safety our items are exposed to the ethylene oxide vapor in the sterilizing chamber for four hours. Table 6 shows the results on culturing test sites on metallic surfaces at 70° F. (25° C.) after two- and four-hour exposures compared to exactly similar sites not so exposed and used as controls. Controls in all experiments were always positive. Fourteen test sites, using seven organisms for each of the three exposure periods, show that sterility is assured after four-hour contact with ethylene oxide vapor.

In our operating room we have sterilized and used the following instruments: hand magnet, loupes, binocular microscope, hand slitlamp, the Berman locator probe, transformers, hand battery cautery (Hildreth), keratomes, scissors, and other sharp instruments, ophthalmoscopes and giantscopes, and tonometers. There is no physical change in the various items exposed to the gas. Heat, for example, will eventually discolor and crack plastic parts, but there is no change in the appearance or usefulness of plastic items after multiple exposures to ethylene oxide.

No additional cleansing, rinsing, or neutralizing of the sterilizing agent from the instruments is necessary. Consequently, there is no danger that an irritating chemical might be introduced intraocularly or topically by means of a surgical instrument.

TOXICITY

The toxic limits of ethylene oxide for human beings are about the same as those for ammonia.[1] In low concentrations the gas does not possess a distinct odor,

(Continued on next page)

TABLE 6

Sterilization of Contaminated Metallic Surfaces by Ethylene Oxide Vapor

(1.25 cc. per liter at 70° F.)

Organism		No Exposure		2 Hr. Exposure		4 Hr. Exposure	
		Growth		Growth		Growth	
		24 hr.	48 hr.	24 hr.	48 hr.	24 hr.	48 hr.
Alpha streptococcus	1	+	+	—	—	—	—
	2	+	+	—	—	—	—
Staph. aureus	3	+	+	+	+	—	—
	4	+	+	?	+	—	—
Escherichia coli	5	+	+	—	—	—	—
	6	+	+	—	—	—	—
Aerobacter aerogenes	7	+	+	—	—	—	—
	8	+	+	—	—	—	—
Ps. aeruginosa	9	?	+	—	—	—	—
	10	?	+	—	—	—	—
Proteus vulgaris	11	+	+	—	—	—	—
	12	+	+	—	—	—	—
Pneumococci	13	—	—	—	—	—	—
	14	+	+	+	+	—	—

but it is sufficiently irritating to give warning of its presence. Reported cases list headaches, nausea and vomiting, and respiratory irritation as symptoms, but no permanent ill effects occurred.[4] In the small amounts used in a 35- or a 60-liter capacity sterilizer, the probability of untoward reaction in human beings exposed to exhausting gas is remote, but, as a precaution, the outlet pipe should be led outside the building.

Cases of accidental blistering of the skin due to exposure to ethylene oxide vapor have occurred. While the liquid when spilled on the skin evaporates rapidly and without causing damage, burns occurred when rubber shoes and rubber gloves were worn by laboratory workers immediately after they had been sterilized by ethylene oxide vapor. Apparently the vapor had dissolved in the rubber and diffused out against the skin. Plastics in general share this property of dissolving this gas. No such incidents have occurred with similar articles of clothing which were aired before being worn.

STERILIZING OF LIQUIDS

Use of ethylene oxide to sterilize liquids, including ophthalmic solutions, is impractical at the present. A sufficient amount of the liquid ethylene oxide must be added to a given solution to bring the concentration to one percent. The container is then stoppered and let stand for six hours or longer. After that time the solution must be exposed to air to allow the gas to evaporate. To hasten this process, the open container should be heated to 60° C., and a 25 pounds per square inch vacuum drawn for one minute.

Studies have not been carried out to determine if there is a chemical reaction between the ethylene oxide and the solution being sterilized. The medication cannot be used clinically until all the ethylene oxide has evaporated. Thus there is no continuing inhibition of contamination with micro-organisms. There is a pH change which must be moderated by various buffers. Dry streptomycin calcium chloride salt loses 35 percent of its potency when treated with ethylene oxide vapor. Penicillin in the dry powdered form showed no diminution of potency.[5] For sterilizing liquids, it is considerably more simple to employ either a Selas porcelain filter or a membrane filter.*

SUMMARY

Ethylene oxide vapor is an effective sterilizing agent against both bacteria and at least the larger viruses. Packaged in a convenient 12-ounce can containing about 80% dichlorodifluoromethane, the ethylene oxide is easily admitted to an ordinary small steam sterilizer which requires only simple modifications for this purpose. A four-hour exposure to ethylene oxide vapor at room temperature killed all organisms tested. Toxicity is a negligible factor in the amounts used here. Bulky items and instruments which are harmed by heat or soaking can be rendered sterile with no damage whatsoever. Plastic, rubber, leather, electrical equipment, wood, and paper are not harmed by this method of sterilization with ethylene oxide vapor.

*Millipore Filter Co., Watertown, Mass.

REFERENCES

1. Phillips, C. R., and Kaye, Saul. "The Sterilization Action of Gaseous Ethylene Oxide, I. Review." *Am. J. Hyg.* 50:270-279, 1941.
2 Kaye, S., and Phillips, C. R.: "The Sterilizing Action of Gaseous Ethylene Oxide: IV. The Effect of Moisture." *Am. J. Hyg.* 50:296-306, 1949.
3. King, J. H., Jr., "Contamination of Eye Medications: Practical Methods of Prevention." *Am. J. Ophth.* 36:1389-1397, 1953.
4. Blackwood, J. D., and Erskine, E. B. "Carboxide Poisoning." *U. S. Naval Med. Bull.* 36:44-45, 1938.
5. Kaye, S., Irminger, H. F., and Phillips, C. R. "The Sterilization of Penicillin and Streptomycin by Ethylene Oxide. *J. Lab. & Clin. Med.* 40:67-72, 1952.

Anesthesiologists Report on Survey Of Deaths in the Operating Room

Death on the operating table is not completely avoidable, William H. L. Dornette, M.D., and O. S. Orth, M.D., point out in the conclusion of a comprehensive article on "Death in the Operating Room," published in the November-December, 1956, issue of *Current Researches in Anesthesia and Analgesia.*

They report on a study of deaths that occurred in the operating room at the University of Wisconsin Hospitals from 1943 to 1954, inclusive.

As more complex surgical interventions are undertaken, they say, the incidence of deaths may increase.

By careful and experienced administration, however, the anesthetist can continue to improve the chances for healthy survival of the patients under his care.

During the 12-year period, 63,105 anesthetics were administered by, or supervised by, members of the department of anesthesia at the hospitals. Of the 63,105, 108 patients (one in 584, or 0.171 percent) died in the operating suite or suffered circulatory arrest and subsequently died without regaining consciousness.

Causes of the fatalities were classified as follows:

Death due to operation	19 cases
Death due to patient's disease	13 cases
Death due to patient's disease and operation	29 cases
Death due to anesthesia	26 cases
Death due to patient's disease and anesthesia	20 cases
Death due to anesthesia, operation and patient's disease	1 case

Thus, the authors point out, 61 of the 108 deaths were attributed to factors other than anesthesia, and only 26 were believed to be due solely to anesthesia. They emphasize that the phrase "death under anesthesia" or "death on the operating table" is hence more accurate than "anesthetic death."

Of the 47 deaths involving anesthesia, the great majority (41 cases) were felt due to faults in administration. Lack of oxygen played a role in 25 of these, and in a large majority of these the myocardium rather than the cerebrum was fatally afflicted.

Two patients died under circumstances which were definitely preventable, the authors state. One suffered massive intravenous air embolism as a result of injudicious use of a pneumatic blood pump. The orderly who had been pumping blood left on another errand with the elevated pressure in the blood bottle.

The other patient was given cyclopropane for induction of anesthesia. Cyanosis soon developed. The oxygen flush valve was turned on, cyanosis deepened, and cardiac arrest followed shortly thereafter. It was later discovered that the nitrous oxide and oxygen supply tubes had been cross-connected.

At the University of Wisconsin hospitals, in every instance in which death occurs during or following the administration of anesthesia, the case is discussed at the next weekly anesthesia staff conference. The cause or causes of death are decided upon after all personnel involved have stated the full facts and sequence of events. Surgical staff members attend the meetings and participate in the discussions when indicated.

Cases are surveyed critically, and suggestions for prevention are made.

Minutes of the meetings are filed for future reference, and all details of the presentation, including discussion, are listed on a death report form for inclusion with the anesthesia record. It was from these reports that data for the article were collected.

SELECTED BIBLIOGRAPHY

Ophthalmic Procedures

Ridley, Frederick. "Safety Requirements for Acrylic Implants." *Brit. J. Ophth.* 41:359, 1957.

Intraocular prostheses of polymethyl methacrylate (acrylic plastic) can be comfortable and safe for the patient if special handling of the plastic is observed. The general requirements for an implant are that it must be insoluble in water and inert to body fluids, and must not provoke tissue sensitization. Pure acrylic meets these specifications, but other products based on the use of the same material may be unsuitable because of fillers and plasticizers.

It is important that the physician know the manufacturing process involved, to be sure that the plastic is never exposed to temperatures above 140° C. Above this temperature, the plastic is changed chemicaliy, and compounds irritating to tissues may be freed. The physician must be certain that in the polishing and grinding process, no product is used which might react chemically with the plastic.

Cleaning and sterilization of the plastic must be done with nonreactive chemicals which contain physiologically acceptable ions. Cationic detergents are likely to be absorbed by the plastic, and non-ionic detergents must be avoided because of the possibility of absorption. An anionic detergent such as pure sodium lauryl sulfate is ideal for the purpose. Throughout the washing and cleaning process, distilled water should be used to prevent the formation of film and scum. To remove all traces of grease from the plastic, 0.1% sodium lauryl sulfate at 40° C. for five minutes is recommended.

Hydrochloric acid is not suitable for use on acrylic plastics because although the plastic is inert to the acid, high concentrations may cause hydrolyzation of the plastic's surface, and the latter would be more likely to adsorb and absorb other substances.

Lenses in acrylic carrying racks are placed in a screw-cap polyethylene container, which is filled with 10% caustic soda and kept at 30° C. for one hour. The solution is then poured off and replaced with a 0.1% solution of caustic soda which remains in the container during storage.

Racks and containers of metal and plastics other than polyethylene should be avoided. In the former, the metal is likely to be attacked by the solution; in the latter, fillers and plasticizers are likely to pass into the solution during storage.

When rubber gloves are used for handling the implants, care must be taken to select gloves which have not been treated with dusting compounds.

At operation, the caustic soda is poured off and the container filled with a 0.5% solution of soda bicarbonate in distilled water. The cap is replaced, the container shaken thoroughly, and the lens and racks kept submerged for five minutes. The bicarbonate solution is poured off, and the lens is removed with a dry heat-sterilized forceps which has been carefully protected from contact with detergent, germicide, or other solutions on the field.

Abbot, C. F., Cockton, J., and Jones, W. "Resistance of Crystalline Substances to Gas Sterilization." *J. Pharmacy and Pharmacology* 8:709, 1956.

A series of experiments is described to prove that viable spores can survive within crystals after exposure to sterilizing gases. When compounds are made from contaminated liquid, spores are included within the crystal and remain protected. Formaldehyde and ethylene oxide will apparently sterilize the outer surface of crystals, but cannot reach the organisms entrapped within the crystal mass.

This mode of contamination occurs in a sufficiently large number of instances to suggest that it is a common occurrence. Since gas cannot be relied upon to sterilize the inside of crystals, sterile solutions must be used for dissolving drugs.

Particular care in sterility testing of this group of compounds is necessary to detect the presence of viable organisms within the crystals.

Elkin, Eugene. "Single-Dose Sterile Unit for Office Use." *Am. J. Ophth.* 43(4):621, April, 1957.

Because of the increasing incidence of infections resulting from the contamination of fluorescein solutions by airborne bacteria or through careless handling, single-dose units are essential to minimize this hazard. An ordinary straight medicine dropper is filled with freshly prepared fluorescein solution and is inverted, bulb side down, while a second bulb is slipped over the opposite end. The solution is allowed to pass freely into the second bulb. The unit is then sterilized in the steam sterilizer and stored until used.

The author suggests the use of droppers with untapered ends, so that the solution can run freely from bulb back into dropper. When placing the second bulb in position, it is suggested that the bulb be deflated so that a partial vacuum is created and the likelihood of its being blown off during sterilization is minimized.

Lawrence, C. A. "An Evaluation of Chemical Preservation for Ophthalmic Solutions." *J. Am. Pharm. Assoc.* 44:457, August, 1955.

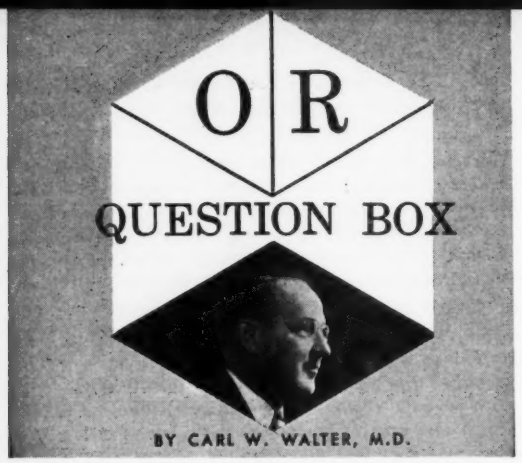
The sources of contamination of eye solutions with Pseudomonas *and* Proteus *include infected droppers, contaminated drugs used in compounding, and contaminated distilled water. Commercially prepared solutions must be sterile by official regulation, but hospital and retail pharmacy products are exempt from this regulation.*

Many factors of control are possible—the use of sterile ophthalmic powders for compounding; the handling of drugs aseptically, and the use of sterile distilled water and dispensing bottles and containers and disposable eye droppers. Benzalkonium chloride 1:5000 appears to be an effective agent for rendering the solutions bacteriostatic.

Craig, P. C. "Sterile Air in Intraocular Surgery." *A.M.A. Arch. Opth.* 51:701, May, 1954.

A technic is described for providing sterile air for introduction into the anterior chamber. A 7 cm. length of plastic tubing (3 mm. diameter) is filled at one end with cotton to a distance of 2 cm., and the whole is autoclaved. When used, a sterile syringe with attached needle or Noyes irrigator is placed in the open end of the tube, and air is drawn into the syringe through the sterile cotton.

(Continued on page 122)



Assisted by Dorothy W. Errera, R.N.

Q. Can operating room nurses wear nail polish?

A. There is no contraindication to the circulating nurse's wearing of nail polish. The scrub nurse, however, should avoid its use, because bacteria protected beneath the surface are freed through cracks and chips which are difficult to avoid or anticipate.

Q. Are dispensers necessary for use after a scrub, or is a dip satisfactory?

A. Germicides should come from a dispenser so that everybody receives fresh solution which is not diluted by the first hands disinfected as is the case with a dip.

Q. After completing a scrub with pHisoHex and rinsing the hands, can you put on more pHisoHex and leave it on the hands?

A. A layer of pHisoHex can be left to dry on the scrubbed hands, but aside from arousing possible dermatologic problems, the technic does not afford the safety achieved by following the scrub with a contrasting germicide.

Q. Can novocaine be resterilized?

A. The chemical composition of novocaine changes too much with reheating to make resterilization feasible.

Q. Where in the scrub do you think nails should be cleaned?

A. The nails can be cleaned anywhere in the scrub cycle. The important feature is that they be kept short and receive sufficient number of brush strokes to loosen and remove dirt.

Q. How do you care for a suction gauge fastened on the wall?

A. The suction gauge never needs care because it never contacts contaminated material. Aspirated fluids are taken through a trap bottle to a second bottle. Unless the system is defunct, they never get beyond the second bottle.

Q. How is polyethylene tubing sterilized?

A. Ideally, polyethylene is sterilized in ethylene oxide. Otherwise, when new it is immersed in an aqueous solution of a quaternary ammonium compound. Once it has contacted blood, it is discarded.

Q. How is silkworm gut sterilized?

A. Silkworm gut is an outdated suture material but can be sterilized in the steam sterilizer at 250° F. for 30 minutes.

Q. What is the difference between soaps and detergents?

A. Broadly speaking, soaps are detergents, but soaps are made of ordinary fatty acids such as coconut oil or tallow (animal fat). Detergents, or, more correctly, synthetic detergents, are made up of long chain hydrocarbon molecules. At one end of the chain is a polar group that likes water (hydrophilic) and at the other, a group that hates water (hydrophobic).

Detergents can be cationic, anionic, or non-ionizing. These terms explain their mode of reaction with other substances. Cationic detergents get in the same difficulty as soaps, because the calcium and magnesium ions in hard water couple with the surface active ions of the detergent and form an insoluble compound. Non-ionizing detergents have the advantage of not coupling with these ions in hard water and hence clean freely.

When synthetic detergents are used, grease and dirt disappear, because as more water is added, the hydrophilic group of molecules float off the dirt solubilized by the hydrophobic group. A small amount of synthetic detergents should be used to solubilize the dirt and grease, and then quantities of water are added to remove the soil.

Q. When instruments are set up on trays for sterilization, is a pan liner important?

A. There is no bacteriological need for a pan liner in steam-sterilizing instruments. It has some value in keeping the instruments from sliding around.

Q. Is there any danger of reaction between a stainless steel plate and a chrome-covered bending iron?

A. When working with metals, it is essential to stick to a single metallurgic system to prevent implants of dissimilar metals and consequent electrolysis. Stainless steel will react with the steel beneath the chrome plate and even more so with aluminum. Plates and screws used in a fracture should be from the same manufacturer.

The harm to the patient from the reactions of dissimilar metals is serious enough to warrant a thorough re-evaluation of fracture fixation equipment in the operating room.

Q. Is there any chance of contamination from air blowing from a hot-air hand dryer?

A. It has been shown that air passing over hot wires to be heated sterilizes itself adequately so that there is no danger of contamination of the skin of the hands. There is a real danger if the blower is located in a dirty room where its downward blast of air stirs dirt up from the floor.

Q. How do you know whether you have roaches in the operating room?

A. By setting out traps at regular intervals. A simple trap is made of an ordinary jelly jar with a strip of adhesive running up the outside. A few drops of water and a bit of dry cereal are placed on the bottom. The roaches are attracted by the smell of food and water, climb the adhesive, jump into the jar, and are unable to escape.

Q. Should the operating room be dusted in the morning before the cases start?

A. The operating room should be dusted the night before, so that dust will have a chance to settle out.

NOW AVAILABLE! THE FIRST STERILE STAINLESS-STEEL BLADE

New SteriSharps® can be autoclaved! Eliminate messy solutions...blade waste!

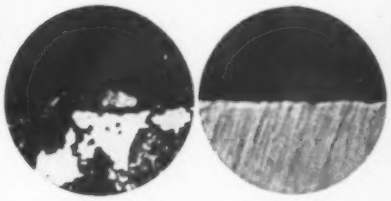
© COURTESY WILMOT CASTLE CO.

New stainless-steel SteriSharps — sharpest blades made — come individually sealed in foil, ultrasonically cleaned, ready for instant use. Save time, simplify technic in the OR.

SteriSharps are used only as needed — do away with the wasteful practice of preparing several blades for each operation. And SteriSharps can be autoclaved, just like other instruments so as to be instantly available to the suture nurse. Sealed packets can be re-autoclaved, stored indefinitely. Will not corrode.

Your supplier has SteriSharps in every design. And a stainless-steel dispenser is yours free with every five gross. Or write: A·S·R Hospital Division, Dept. HT, 380 Madison Avenue, New York 17, New York.

AUTOCLAVE TEST PROVES STERISHARPS SUPERIORITY



ORDINARY BLADE STERISHARP

One of a series of tests which demonstrated the superiority of SteriSharps in hospital use subjected a SteriSharp and an ordinary surgical blade to autoclaving—under 18 pounds of pressure at 250°F.—for 30 minutes. The ordinary blade (left) was severely corroded and stained, and the edge became rough and impaired. The SteriSharp (right) did not corrode. The cutting edge was unaffected. Actual photos shown are magnified 1,000 times.

A·S·R precision products

SteriSharps . . . the first sterile, stainless-steel surgical blade

▪ literature and samples available

NOW . . . STERILE WITHOUT GLASS

revolutionary

Saves 33⅓% nurse time[1]

—no large, clumsy tubes to break, no reels to unwind . . . new nurses learn simple SURGILAR technic in minutes

Gets broken glass out of the O. R.[1]

—no nicked sutures . . . no adhering glass slivers . . . no punctured gloves . . . no glass in laundry . . . nonirritating jar solution— all important contributions to better patient care

MORE THAN ~~1,500~~ 2,000 HOSPITALS HAVE ALREADY SWITCHED TO SURGILAR

Write for new product catalog
SURGICAL PRODUCTS DIVISION, AMERICAN CYANAMID COMPANY, DANBURY, CONNECTICUT
CYANAMID PRODUCERS OF DAVIS & GECK SUTURES

CYANAMID 50 1907 1957

NEEDLE SUTURES HAZARDS!

D&G SURGILAR®

Sterile Pack
Standard Lengths

Surgical Gut
ATRAUMATIC® Needles

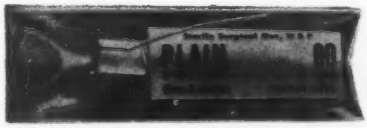
Delivers stronger, more flexible sterile sutures[1]

—eliminates weak spots and kinks from tight reel winding...requires less handling...can be easily opened as needed so suture does not dry out...needle points and cutting edges are better protected

Cuts surgical costs[1]

—fewer sutures damaged or opened unnecessarily...saves gloves and linens...stores in ½ the space...*now costs less than tubes!*

1. Alexander, Edythe L.: Mod. Hosp., May, 1957.



NEW! Spiral Wound Gut now available in SURGILAR pack!

Other outstanding *hospital-tested* suture packages

SURGILOPE®

Sterile Pack Pre-Cut Silk and Cotton...aluminum foil envelopes... no glass to break...⅓ less storage space...costs less than tubes

MEASUROLL®

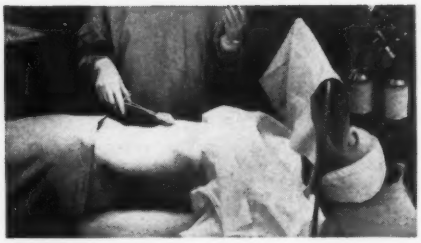
Silk, Cotton and Stainless Steel ...tape-measure box...one snip cuts multiple strands to desired length...saves waste, saves time...economy size silk and cotton costs less than spools

EMERGENCY ROOM EFFICIENCY

Visible sterile storage with Zephiran 1:5000 to 1:1000 aqueous solution (with Anti-Rust Tablets "Winthrop") makes presterilized instruments, ampuls, etc., easily accessible and ready for immediate use. Zephiran 1:5000 solution is also particularly valuable and efficient in the cleansing and debridement of wounds.

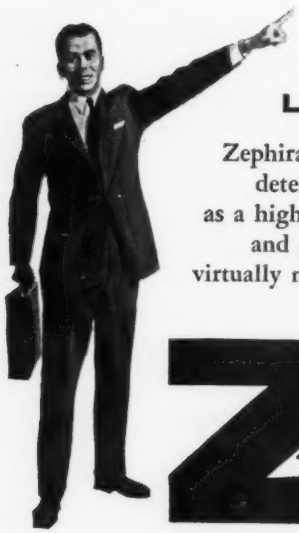
ANTISEPSIS IN THE OPERATING ROOM

Chemical antisepsis with Zephiran 1:1000 stainless tincture is a ritual in the scrub-up room. Zephiran is most widely used in hospitals to prepare personnel, patient and equipment for surgery.



ANTISEPTIC DIP BASIN

Zephiran is just as valuable outside the operating room area to minimize the hazard of infection during ward rounds, bed-to-bed care and general servicing. A small basin with 1:1000 Zephiran aqueous solution or tincture right on the cart or utility table gives greater assurance of continuing antisepsis.



LET ZEPHIRAN WORK FOR YOU

Zephiran is dependable, safe and economical. A refined cationic detergent with unusual wetting and spreading ability as well as a highly potent antiseptic—Zephiran *kills* many gram-positive and gram-negative bacteria *in seconds*. It is nonirritating and virtually nontoxic. Zephiran has hundreds of uses in daily practice.

REFINED BENZALKONIUM CHLORIDE

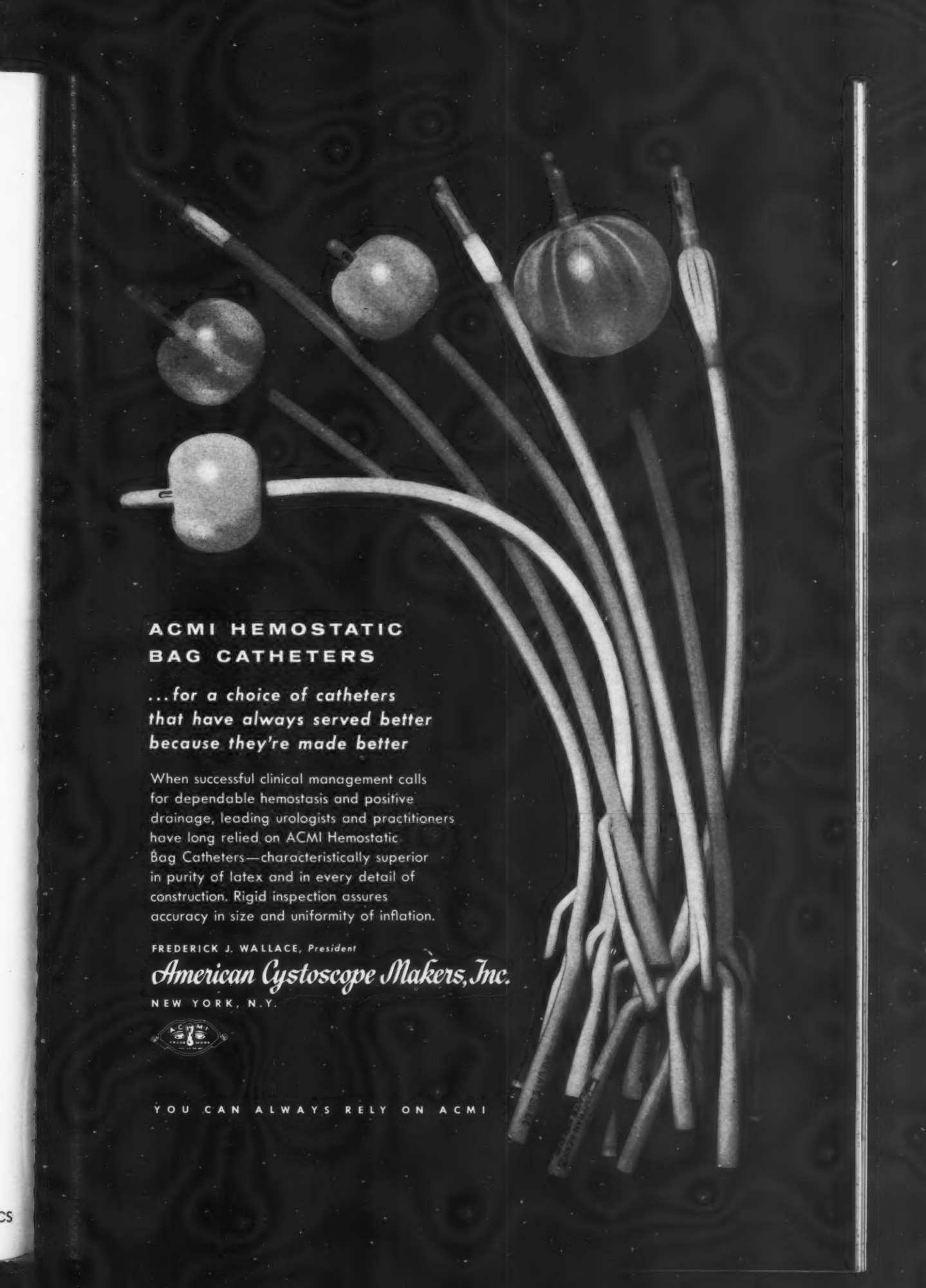
Zephiran®

CHLORIDE

Winthrop LABORATORIES, New York 18, N. Y.

2149 H

ZEPHIRAN, (BRAND OF BENZALKONIUM, AS CHLORIDE, REFINED), TRADEMARK REG. U. S. PAT. OFF.


ACMI HEMOSTATIC
BAG CATHETERS
...for a choice of catheters
that have always served better
because they're made better
When successful clinical management calls for dependable hemostasis and positive drainage, leading urologists and practitioners have long relied on ACMI Hemostatic Bag Catheters—characteristically superior in purity of latex and in every detail of construction. Rigid inspection assures accuracy in size and uniformity of inflation.
FREDERICK J. WALLACE, President
American Cystoscope Makers, Inc.
NEW YORK, N.Y.
YOU CAN ALWAYS RELY ON ACMI

O.R. BIBLIOGRAPHY

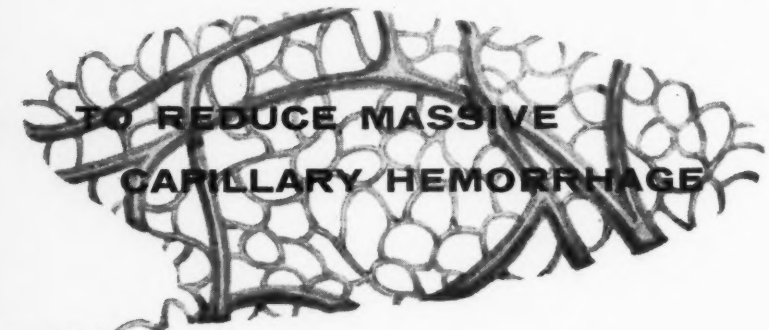
(Continued from page 115)

Schwartz, F. E., and Linn, J. G., Jr. "The Effects of Glove Powders on the Eye." *Am. J. Ophth.* 34:585, April, 1951.

With the increasing use of rubber gloves in ophthalmic surgery and the documented evidence that dusting powders caused granulomatous lesions in tissues, it appeared logical to determine the specific effects of these powders on the eye. Varying amounts of talcum powder, potassium bitartrate, and Bio-Sorb were injected into the anterior chamber of some rabbits' eyes and injected under the superior rectus muscle of the eyes of others.

It was determined that 0.1 cc. of a 0.3% solution was equivalent to what might be expected to contact the eye under actual operating conditions. It was also allowed that the experiments were conducted on normal eyes, while under actual operating conditions, eyes involved would have been previously diseased, and even a smaller amount might be sufficient to activate the original infectious process.

In all experiments, ordinary talcum powder caused distinctive granuloma; Bio-Sorb produced lesions of a less severe nature. Potassium bitartrate appeared to be innocuous in the eye, but its use as a dusting compound is contraindicated because of inherent characteristics which make it difficult to sterilize and to use and because of its deleterious effect on rubber.



Kutapressin®

Kutapressin—a highly selective vasoconstricting derivative from liver—acts with promptness on abnormally dilated therminal arterioles and capillaries—without increasing systemic blood pressure.

The rapidity with which Kutapressin constricts dilated vessels, decreases permeability, eases local congestion, suggests its wide range of usefulness in the hospital.

- Prevention and reduction of capillary bleeding encountered in tonsillectomies, adenoidectomies and other procedures
- In preparation of third degree burns for grafting
- Helps keep surgical field clean
- Plastic surgery
- Eye and brain surgery
- Reduces tissue trauma due to sponging

No systemic side reactions have been observed following its use.
It is free from protein material, is not antigenic, is well tolerated.
No untoward effects have ever been reported.

Kutapressin may be administered intramuscularly or subcutaneously.

Supplied: Aqueous Solution, 2 cc. ampuls; 10 cc., 20 cc. multiple-dose vials.

Send for literature and samples

Ethical Pharmaceuticals Since 1894

KREMERS-URBAN COMPANY MILWAUKEE 1, WISCONSIN

Prescribe with Confidence

Find Hormone-Fed Animals No Hazard to Humans

Meat from hormone-fed animals has been found safe for humans, according to George M. Briggs, Ph.D., Bethesda, Md., in a special report to the American Medical Association's Council on Foods and Nutrition.

Studies indicate that traces of hormone remain in some meat from beef cattle and poultry, but ordinary daily amounts of meat would not result in consumption of very much of this material.

Anti-TB Vaccine Good for Children

78 to 100% Effective

BCG vaccine has reduced tuberculosis in children 78 to 100 percent. Death from tuberculosis, particularly tuberculous meningitis and miliary tuberculosis in the first year of life, has practically been eliminated following the intradermal and/or multiple-puncture method of vaccination.

A 20-year study on American Indians shows an 80 percent reduction in mortality from tuberculosis and 73 percent reduction in morbidity.

BCG vaccination has decreased the incidence of tuberculosis in all age groups as compared to non-vaccinated controls. The vaccine in the freeze-dried form is standardized for safety, viability, and potency, and should be considered an adjunct to the proven methods of tuberculosis control—**Sol Rosenthal, M.D., Ph.D.**, Associate Professor of Preventive Medicine, University of Illinois College of Medicine, Chicago. (Abstract of a paper presented at the annual convention of the American Society of Medical Technologists in Chicago recently.)

Public Relations Director Accepts New Position

Roger E. Davis has resigned as secretary and public relations director, Hospital Service Association of Western Pennsylvania, to become assistant vice-president and public relations director, Associated Hospital Service of New York (Blue Cross) and public relations director, United Medical Service, Inc. (Blue Shield).

Applying Industrial Methods in Hospital Laboratory Operations

By Arthur Allen*

● Industry has long recognized that for effective budget forecasting, evaluation of performance, and control of expenditures, units of work are essential—that is, there must be standards or criteria for the time required to perform each task or operation.

Few hospitals have employed such criteria, apparently because they believed that laboratory operations do not lend themselves to measurement. This assumption, however, ignores the fact that the majority of laboratory tasks are of a repetitive nature. The experience in industry is that tasks which are often repeated and which have various factors that influence time of performance can have standard times, because the extreme variations will balance.

It is essential that such standards be applied on a mass rather than a single basis. For example, if a study shows that it takes an average of five minutes to perform a task that varies from 1.5 to nine minutes, the average can only be used in determining the total time needed for performance of all identical tasks in a day, week, month, or year. This standard cannot be applied on an individual basis—it cannot be said that eight minutes is too long in the performance of a single operation.

In evaluating the study it must be noted that where the variability is high (the scatter or dispersion around the average) the average will have little meaning.

GENERAL STANDARDS

To determine the reasonableness of present staffing of the laboratories and future staffing needs based on projection of growth, and to evaluate present performances, such standards were developed. A study was made of the time requirements of each major group of laboratory procedures in eight different hospitals. A detailed analysis was also made of time of performance of individual tests in our own laboratory.

It was found that the time required to perform each group of tests was subject to a number of variables, the most important of which were:

1. Division of responsibilities. The amount of time that technicians spend on other than actual laboratory procedures affects performance time.

2. Extent of mechanization—particularly the amount of glass-washing equipment.

3. Size of work load. Certain tests may be performed simultaneously, so that time per test is lowered substantially.

4. Type of work load—types of tests performed.

5. Work flow—the physical arrangement of the department.

METHOD USED

General standards were arrived at by dividing the total technician time by the work load. Included in the general standard are time loss and time spent on non-laboratory functions. As previously noted, the number and concentration of routine tests affect the time per test. It was found, however, that hospitals performing routine tests simultaneously are likely to be those which make long, specialized examinations. Consequently, the size and the type of work load balance fairly well.

Excluding factors which relate primarily to operating efficiency, the annual average time per test by major units—bacteriology, chemistry, serology, and hematology—should be approximately the same, regardless of the size of the institution.

Following is the average time required to perform a test in each major laboratory function:

Bacteriology	8.9 minutes
Chemistry	7.4 minutes
Serology	5.0 minutes
Hematology	8.1 minutes

It was found by detailed examination that variations from the norm usually were attributable to the relative efficiency of the laboratory. Where the average time per test was below the norm, the laboratories were found generally to be efficient.

USE OF STANDARDS

General standards are useful in providing broad indications of operating efficiency, for developing personnel requirements for budget purposes, and for indicating whether or not a detailed study of the laboratory operations is indicated.

In applying the "average time per test" criteria, the entire work load of the laboratory, for several months or a year, should be divided into the major groupings—bacteriology, chemistry, serology, and hematology. The number of tests performed should be divided by the number of minutes of technician time worked during the period under study.

For example, in a hospital in which two technicians are assigned to serology, and 11,200 serology examinations are performed in a three-month period, the average time per test would be 5.57 minutes. This was arrived at by dividing the 62,400 minutes of working time of the two technicians by the 11,200 examinations. The 5.57 minutes per examination is 11 percent over the five-minute norm. This finding would indicate a need for further study of this operation.

Detailed studies in several hospitals indicated that the unit time for certain types of tests tended to decrease toward an optimum point as the number of tests run at one time increased. Exhibit 1 presents information based on experience in a number of institutions in which the actual time per ex-

(Continued on next page)

*Mr. Allen is superintendent, Rockaway Beach Hospital, Far Rockaway, N. Y.

amination was reduced toward an optimum point as the volume increased. Laboratory technician performance should substantially correspond to this curve for the examinations listed.

If a wide variance is observed, however, it can be presumed that there is a substantial defect in the operations of the laboratory. In some institutions, the time per examination remained fairly constant, regardless of the increase in work load. In such instances, it was found that the work flow was poor or that effective use of equipment was not made.

The time per examination could even decline as the work load increases. The technician doing Wasserman tests can complete one examination in x units of time. Only a little additional time is required to do 20 Wassermans. However, this would not be true in doing blood counts.

DETAILED ANALYSES

The general measurement of performance discussed above does not provide sufficient information for identifying specific defects in the operation of the laboratory. Detailed analyses are necessary if it is found that the average time per examination in any of the four laboratory functions is high. Detailed studies should also be made in all large hospital laboratories. The should include:

1. Analysis of work flow
2. Study of time required to perform repetitive tests
3. Careful review of time spent by technicians on nonproductive activities.

It should be borne in mind that the disparity between the so-called "norm" and the time consumed by a given laboratory may be the result of faulty measurement (so that in reality heterogeneous things are being compared) as well as to qualitative differences. Suppose, for example, that the staff of hospital laboratory A includes an individual who keeps records, sends out reports, answers the telephone, etc., but whose job is not classified as that of a technician, while in hospital laboratory B these duties are performed by staff members who are listed as technicians.

The total loss of time in hospital laboratory B is likely to exceed the time required for the actual performance of these additional duties (keeping of records, etc.).

TIME OF PRINCIPAL PROCEDURES FITTED TO A CURVE

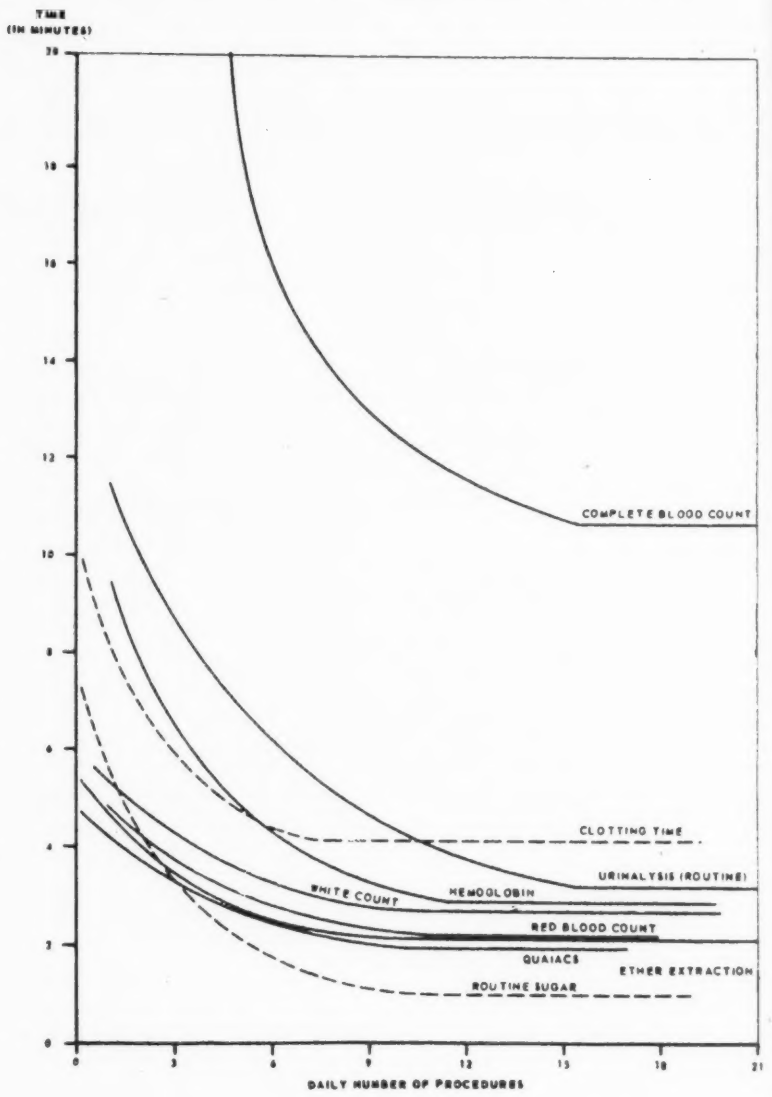


Exhibit I

ANALYSIS OF WORK FLOW

The work flow in hospital laboratories has generally not been reduced to practices that are substantially standard. Opportunities exist, however, for obtaining substantial savings in operating costs by the installation of modern equipment, standardization of performance, and simplification of procedures and work flow.

To determine the effectiveness of the present operation, and to plan new procedures, flow-process charts should be used. The flow-process chart is a graphical representation of the sequences of all operations, transportations, inspections, and storages occurring during a job or procedure. It clearly portrays work elements and brings to light many previously unknown facts about the operation. Exhibit 2 (page 125) is a flow-process chart for performing a routine white-cell blood count.

Each employee has his own rate of speed or pace in performing a job. Adjustments must be made in the actual time required for performance, as it is necessary to determine how long it takes to perform the job if the normal operator works at a normal rate of speed. The resulting performance time is referred to as the "normal time required" to do the job.

(Continued on page 127)

FLOW PROCESS ANALYSIS

Exhibit 2

SUMMARY	NO.	TIME (Min.)	DIST.
OPERATIONS ○	10		
INSPECTIONS □			
MOVES ⇨	8		45′
DELAYS D			
PERM. STORAGE ▽			
TEMP. STORAGE ▽	5		
TOTAL	23	2.76	45′

PRESENT METHOD ☐ PROPOSED METHOD ☐

SUBJECT CHARTED: Performing Routine White Cell Blood Count

DEPT.: Routine Hematology Laboratory

EQUIPMENT, TOOLS, etc.: Pipette, WBC solution, pipette shaker, counting chamber and microscope

ANALYST:

NO.	DESCRIPTION	ACTIVITY	DIST.	TIME
1	Obtain blood specimen tubes from storage area	○□⇨D▽		
2	Arrange blood tubes and result tickets in numerical	○□⇨D▽		
	order	○□⇨D▽		
3	Pick up specimen tube	○□⇨D▽		
4	Shake specimen tube	○□⇨D▽		
5	Remove rubber stopper from specimen tube and pipette blood	○□⇨D▽		
6	Place stopper in specimen tube and return tube to work area	○□⇨D▽		
7	Draw WBC solution into pipette	○□⇨D▽		
8	Place pipette on shaker	○□⇨D▽		
9	Remove pipette from shaker	○□⇨D▽		
10	Place contents from pipette into counting chamber	○□⇨D▽		
11	Place pipette in soiled storage	○□⇨D▽		
12	Place counting chamber in microscope	○□⇨D▽		
13	Count white blood cells	○□⇨D▽		
		○□⇨D▽		
14	Record results of count on corresponding result	○□⇨D▽		
	ticket	○□⇨D▽		
15	Remove counting chamber from microscope	○□⇨D▽		
16	Clean counting chamber	○□⇨D▽		
17	Separate completed result ticket	○□⇨D▽		
18	Transport result tickets to storage area	○□⇨D▽	25′	
19	Deposit original result ticket in box for delivery	○□⇨D▽		
	to proper nursing station and the duplicate copy	○□⇨D▽		
	for filing in laboratory	○□⇨D▽		
20	Transport soiled pipettes to sink	○□⇨D▽	10′	
21	Clean pipettes	○□⇨D▽		
22	Return clean pipettes to work area	○□⇨D▽	10′	
23	Store clean pipettes at work area	○□⇨D▽		
	TOTAL	10 8 5	45′	

TIME STUDY OPERATION SUMMARY

Department Routine Hematology Laboratory

Operation Performing Routine White-Cell Blood Count

Unit of study 1—White-Cell Blood Count Observer

No.	Elements	Element Time	Units	Normal Time
1	Obtain blood specimen tubes from storage area and arrange tubes and result tickets in numerical order	0.28	1	0.28
2	Pick up specimen, shake, pipette blood, draw WBC solution into pipette and place pipette on shaker	0.55	1	0.55
3	Remove pipette from shaker, prepare counting chamber and place pipette in soiled storage area	0.35	1	0.35
4	Place counting chamber in microscope and count white blood cells	0.96	1	0.96
5	Record results on corresponding result ticket	0.15	1	0.15
6	Remove counting chamber from microscope and clean counting chamber	0.29	1	0.29
7	Separate completed result tickets	0.07	1	0.07
8	Transport result tickets to storage area	0.20	10	0.02
9	Transport soiled pipettes to sink	0.10	10	0.01
10	Clean pipettes	0.70	10	0.07
11	Return clean pipettes to work area	0.10	10	0.01

Allowances				Normal Time Required, Minutes		2.76
Process	20.0 %	Personal	8.5 %	Allowances	33.5 %	0.93
Fatigue	5.0 %			Standard Time Required, Minutes		3.69
				Standard Number of Tests per Hour		16.3

Exhibit 3

Standard Time Data for Routine Examinations Performed in Hospital Laboratories

Examination	Unit	Standard Time Required Per Unit (Minutes)	Units Produced Per Hour
ROUTINE HEMATOLOGY			
Cell volume	1	2.37(a)	25.3
Hemoglobin	1	2.61(a)	23.0
Red-cell count	1	5.80(c)	10.3
White-cell count	1	3.69(c)	16.3
Differential cell count	1	6.14(c)	9.8
URINE LABORATORY			
Urinalysis	1	3.70(b)	16.3
CHEMISTRY LABORATORY			
Blood sugar	1	3.17(a)	19.0
Urea clearance	1	8.24(a)	7.3
Urea (blood)	1	4.42(a)	13.6

(a) Process allowances of 10 percent were allowed for these tests.
(b) Process allowances of 15 percent were allowed for this test.
(c) Process allowances of 20 percent were allowed for these tests.
Notice:—The above standards were developed for a specific clinical laboratory. The standards were determined after the specific method of performing the examination was selected. The method of performing each examination *must* be the same before the above standards may be applied to other clinical laboratory operations.

Exhibit 4

After the individual elements of a job and their sequence of performance are identified, time required for each element must be established. This is done by observing each technician and timing each factor with a stop watch. Exhibit 3 is an example of time analysis for a white-cell blood count.

When personnel are observed and timed, there is a natural speed-up for which compensations must be made if true norms are to be established. There are often other factors for which added time must be allowed, in addition to the normal time required for the performance of major tasks. For example, in the case of technician performances, the following allowances are reasonable:

Process—20 percent (interruption in the procedure such as a call from a doctor or nurse regarding a report.)

Personal—8.5 percent (time required to travel to and from the work area and 15-minute rest period in a.m. and p.m.)

Fatigue—five percent (allowance for slowdown resulting from fatigue as the day progresses.)

TIME NEEDED FOR REPETITIVE TESTS

Procedures performed in the different laboratories may be classified as repetitive or nonrepetitive tests. A repetitive test may be defined as one containing a number of operations and procedures that are performed in the same sequence over and over again, with little variation. The following examinations may be classified as repetitive tests:

1. Routine hematology laboratory
   a. Cell volume
   b. Hemoglobin
   c. Red-cell count
   d. White-cell count
   e. Differential cell count
2. Urine laboratory
   a. Urinalysis
3. Chemistry laboratory
   a. Blood sugar
   b. Urea (blood)
4. Serology laboratory
   a. Serology

In contrast, many of the tests performed in the bacteriology, special hematology, and chemistry laboratories are of a nonrepetitive nature—that is, many variables may be encountered in their performance.

It is possible to develop standards of performance or production standards for repetitive tests similarly, as was done in the white-cell blood count example (see Exhibit 2, page 125, and Exhibit 3, page 126). The development of the standards is accomplished by the following five-step process:

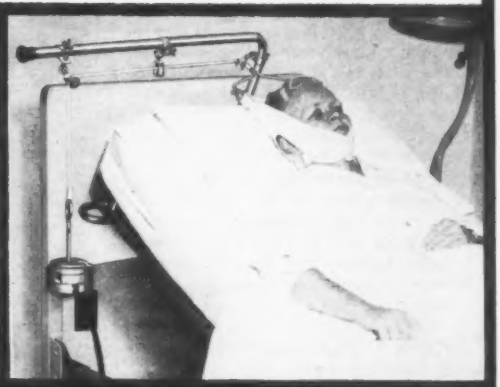
1. Construct a flow-process chart for each test.

(Continued on next page)

CERVICAL+PELVIC TRACTION

WITH NEW DePuy TRACTION FRAME No. 700

Moves up with bed backrest!



This outstanding new frame can be quickly attached to any hospital bed. Supporting base clamps to bed spring frame, which permits elevating the entire frame with the backrest while cervical traction remains unchanged. The unit can be set up, as shown, eliminating the need for moving bed out from wall. Or, pulley-bar can be extended over head of bed if more convenient. For pelvic traction the unit is set up at foot of bed with pulley-bar inverted for greater height. Easy to use, sturdily constructed, folds flat for storage, and it's inexpensive. No. 700. Write for complete information!

SINCE 1895—STANDARD OF QUALITY
DE PUY MANUFACTURING CO., INC.
WARSAW, INDIANA

This Man Knows How to help prevent O. R. Explosions!

with correct floor Maintenance

How do you maintain conductive floors? Ask your Huntington Representative. The company he represents has spent many years testing and analyzing materials to protect conductive floors. This research resulted in an entirely new type of wax (C-2C) and a cleaner (Spal Concentrate) for the special care of conductive floors. Neither product impairs conductivity; both improve appearance of floors and make them easier to keep clean and sanitary. C-2C is the only wax listed by Underwriters' Laboratories Re-examination Service for conductive floors. Spal Concentrate was the cleaner used in the same series of extensive tests. Write today for a demonstration of these products on your floors.

Ask for The Man Behind the Drum

Nearly a half century of experience in dealing with specialized hospital problems is at your service without cost when you contact the Man Behind the Drum . . . your Huntington Representative.

HUNTINGTON LABORATORIES
INCORPORATED
Huntington, Indiana
Philadelphia 35, Pa. • Toronto 2, Ont.

2. Analyze the flow-process chart of each test to eliminate, combine, or change the sequence of the operation.

3. Determine the actual time required to perform the test.

4. Determine the allowance for each test.

5: Determine the number of operations that can be produced per technician hour.

Exhibit 4 presents a list of standard time data developed for routine laboratory tests. The standard data presented in this exhibit were developed for a specific laboratory according to the methods of operation and the equipment used in the laboratory. The standards are presented only as an example, rather than a source of information.

Having available the standard time required to perform the routine laboratory examinations, in minutes, one can evaluate the work performance of the technicians working in these areas according to the specific conditions of the individual hospital.

NONPRODUCTIVE TIME

To determine the nonproductive time of the technicians, each technician should tabulate for a two-week period the number of examinations performed by type and kind, the time required for each examination or series of examinations performed simultaneously, and the time devoted to other than actual laboratory procedures. From this information, a detailed tabulation can be made for each technician of the amount of time spent in active laboratory procedures, the time spent in non-laboratory procedures, and the amount of unaccounted for, or lost, time. A sample form used for recording this information is shown in Exhibit 5.

Analysis of other than actual laboratory procedures may be expected to indicate that time is spent principally on the following:

(1) Recording the findings from laboratory tests in a logbook

(2) Taking blood from patients

(Continued on page 134)

LABORATORY UNIT _____ DATE _____

LENGTH OF TIME IN PRESENT POSITION _____ JOB TITLE _____

TIME BEGAN WORK TODAY _____ TIME ENDED _____

TYPE OF TEST	NUMBER PERFORMED	TIME SPENT

TIME SPENT OTHER THAN ON ACTUAL LAB PROCEDURES

FROM (TIME)	TO (TIME)	PURPOSE OR ACTIVITY

Exhibit 5

keeping tab on the lab

By Marlene Burgess*

The Joint Blood Council

● An organization of great potential service to hospitals and to laboratory personnel is the Joint Blood Council, formed in March, 1955. In its papers of incorporation, the following purposes are described:

"To develop ways and means to make blood and its derivatives available to all persons in the United States; to stimulate and advise on areas of research in the collection, preservation, and use of blood and its derivatives; to collect, study, and disseminate information on blood and blood derivatives;

"To establish minimal standards for voluntary accreditation of blood banks and to establish a means of inspection for accreditation; to coordinate existing systems and encourage and institute plans where necessary for the exchange of blood or blood credits between accredited banks on a state, regional, and national basis;

"To encourage the public through appropriate means to donate blood for civilian and defense requirements and to assist in the establishment of uniform national publicity policies; to disseminate annually a list of blood banks accredited by this organization;

"To serve upon invitation as a fact-finding and arbitration body in disputes arising from the collection and use of blood and its derivatives; to serve upon invitation as an advisory group to federal and military agencies having to deal with blood and its derivatives."

Five constituent organizations participate in the Joint Blood Council, on a completely voluntary basis, by having representatives on its board of directors. These organizations are: American Hospital Association, American Association of Blood Banks, American Society of Clinical Pathologists, American National Red Cross, and American Medical Association.

The Council has definite policies established in its bylaws regarding such important items such as the blood situation in the event of a national emergency, charges for blood, blood replacement, and other related matters.

The council's program is under the direction of Frank E. Wilson, M.D., its executive vice-president, who is in Washington, D.C. Several committees are already at work on pertinent problems. The scientific committee is attempting the development of minimal standards and ideal methods of blood-bank procedures. The insurance of safe blood for the recipient is the purpose of these phases of the program.

A committee on blood insurance problems is also at work and may come up with some new ideas for this phase of blood-banking.

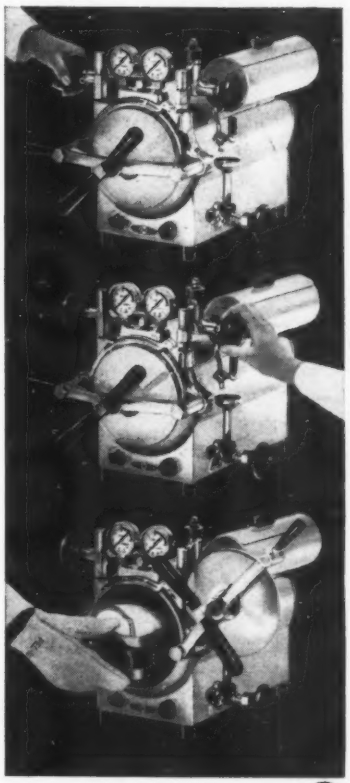
(Continued on page 134)

WHY BOIL?

when you can sterilize FASTER and SAFER in the

PELTON AUTOCLAVE

So Easily Operated



TRANSFER
After loading, simply transfer steam from reserve to sterilizing chamber. In only a few seconds, temperature is attained.

DISCHARGE
When sterilization is completed, discharge steam to condenser after closing transfer valve and crack open the door.

UNLOAD
In a minute or two entire contents are removed completely sterile and dry. The autoclave is ready for second load.

AVAILABLE IN 3 SIZES:

Model FL-2,
6" x 12" sterilizing chamber
•
Model HP-2,
8" x 16" sterilizing chamber
•
Model LV-2,
12" x 22" sterilizing chamber

See your dealer or send coupon.

the Pelton & Crane company
CHARLOTTE 3, NORTH CAROLINA

Gentlemen: I am interested in the Pelton time-saving Autoclave. Please send me more information and prices on model.

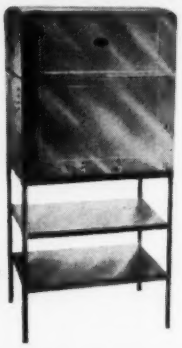
☐ FL-2 ☐ HP-2 ☐ LV-2

Name_____

Address_____

City & State_____

1.



KLEEN-O-MATIC

Syringe and glassware washer

Thoroughly wash and rinse up to 2,000 syringes in a 15-minute cycle. Also process asepto syringes, needle constriction tubes, solutions — closure parts, medicine glasses, surgical instruments and a wide variety of Central Supply, Pharmacy and Lab glassware. Welded, stainless steel construction.

2.

KLEEN-O-MATIC

Needle Washer

Process 700-1,000 needles an hour; clean *all* vital parts of needle. Twenty-second wash-rinse cycle controlled by fully automatic timer. Increase efficiency, eliminate burring, protect against hepatitis and dermatitis by handling plastic manifold holding 12 needles instead of handling needles themselves. Simple installation requires no air tubes, no bulky gas tanks.

3.

GLOVEMASTER

Dry and powder up to 100 gloves per load. Removable aluminum drums facilitate handling, improve work flow. Consumes only 18" of wall space.

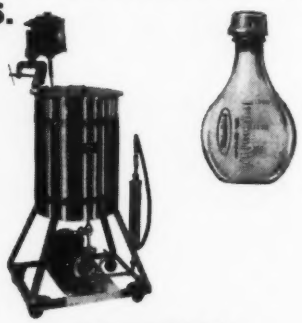
4.

MOBILE EQUIPMENT

and work stations

MacBick offers a complete line of adjustable shelf and fixed shelf CSR utility trucks, flask drain trucks, portable kit tables, custom designed work stations, counterwork and storage shelving.

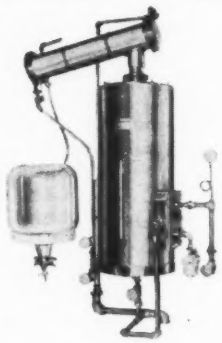
5.



SOLUTION PREPARATION EQUIPMENT

Stainless steel tank unit for 200-unit batch preparation and filtration of solutions; cuts costs, increases efficiency, provides effective control. POUR-O-VAC Pyrex flasks, self-sealing vacuum closure, identification tags and accessories provide a complete, safe system for preparing sterile surgical fluids.

6.



BARNSTEAD WATER STILLS

Famous, dependable Barnstead Q-baffle water stills provide the large volume of pyrogen-free distilled water so necessary for modern CSR techniques. New de-ionizer filter condensate feedback attachment completely eliminates need for cleaning.

mechanize, mobilize, modernize with

MACBICK

one source of supply for central supply

FREE

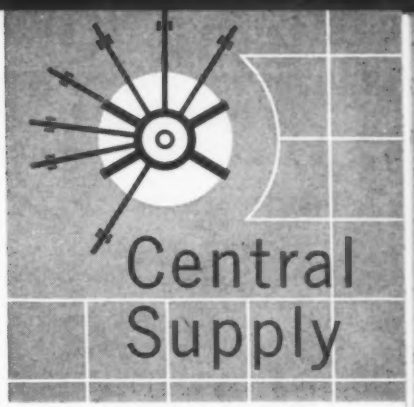
ARCHITECTS: up-to-date CSR planning requires layout provision for up-to-date CSR equipment. Write for MacBick CSR DATA FILE with descriptive literature, specifications and rough-in drawings on equipment above. Local MacBick hospital specialist will be pleased to assist in work-flow analysis of specific CSR projects.

MacBick

THE MACBICK COMPANY

Formerly Macalaster Bicknell Parenteral Corporation
Dept. D, Broadway, Cambridge 39, Massachusetts

Disposable Needles Meet Need for Sharpness, Sterility



By Randall B. Tinker* and Richard A. Hill**

● Utilization of the disposable hypodermic needle is already an accepted practice in many modern hospitals. Latest advancements in disposable needle technology indicate that the sterile, individual unit will soon be marketed. Cost estimates show that the time saved in central sterile supply areas alone will provide economic justification for its use.

High cost, of course, has been a major drawback to widespread use of disposable needles up to the present time.

The disposable needle provides the answer to two principal problems: needle sharpness and sterility.

1. **Sharpness.** A needle should be so designed and constructed as to assure application of the parenteral medication at a desired site with a minimum of tissue trauma and after-effect. Unfortunately, meticulous attention to the condition of the needle point is required to obtain these attributes.

Conventional needles—those which are reused—must undergo individual examination during processing in the hospital. Those which fail under observation, because of a burred or worn point, must be either discarded or resharpened. Frequent failures by personnel involved in checking this characteristic lead to increased tissue trauma and patient complaint.

2. **Sterility.** Medical literature is scattered with reports of cross-infection, injection abscess, and other conditions resulting from improper cleaning and resterilization of hypodermic needles. The difficulties encountered are inherent to the design of the needle itself.

Complete sterilization by any means depends upon the accessibility of the cleansing and sterilizing media to the surface being treated. The small lumen of the average hypodermic needle is one of the most difficult areas to reach in surgical sterilization. No guarantee of successful results has ever been anticipated; the situation has merely been tolerated, since no alternative existed. The high replacement cost of conventional needles precluded, in general, a single use followed by immediate destruction.

The element of disposability was first utilized by the military services in the early 1940's for single-dose units of morphine and of penicillin. These were not true disposable needles, but merely an adaptation of conventional needles. Their high cost could only be justified by the emergency situation then prevailing.

Production of a true disposable needle must be credited to Roehr Products Co., Inc., of Waterbury, Conn., and DeLand, Fla. Sensing the potential market for such a needle in disposable intravenous sets, the company undertook, in 1947, a program which led to the perfection of disposable needle design and manufacturing technics.

The needle was required to meet all existing specifications, yet be of such low cost that it would be expendable after one use. These requirements were met, and the needle was introduced on the market by Abbott Laboratories in their sterile blood and solution administration sets. The same needle, with only slight modification, is being supplied with almost every disposable parenteral set on today's market.

The introduction by pharmaceutical manufacturers of the disposable, prepackaged, single-dose unit (syringe, medicament, and needle) to the general trade required the inexpensive disposable needle. This need was likewise met, and the available range of sizes and gauges further increased.

It was not until early 1954, however, that the disposable needle was removed from the manufacturer's realm and introduced to hospitals and clinics for use in routine parenteral administration of medications. The needle gained immediate acceptance, since it provided an answer to the continual problems of sharpness and sterility. A new point at each use afforded a measure of protection against tissue trauma, and immediate disposal eliminated costly and inefficient cleansing procedures.

A means of affording patients maximum safety and comfort had been placed in the hands of every responsible hospital staff. That this could be done in an economical manner was a triumph of modern manufacturing technology.

Disposable hypodermic needles now appearing on the market are manufactured and distributed in the United States by Roehr Products Co., Inc., and Becton, Dickinson and Co. A Japanese-manufactured disposable needle finds outlet through Edco Surgical Supply Co., Inc.

Although the hubs of the disposable needles vary in alloy and design from the hub of the conventional hypodermic needle, the cannula tubing is of the same type alloy as that found in needles manufactured to federal specifications.

The needle is designed primarily for use with the slip-on syringe, but is also adaptable to Luer-type connections. The grinding and cutting processes and surface treatments produce a needle point that has been shown

(Continued on next page)

*Interim assistant research professor, College of Pharmacy, J. Hillis Miller Health Center, University of Florida, Gainesville; consultant-in-pharmacy, Alachua General Hospital, Gainesville.
**Staff pharmacist, Alachua General Hospital, Gainesville, Fla.; presently Fellow of the American Foundation for Pharmaceutical Education, College of Pharmacy, J. Hillis Miller Health Center, University of Florida, Gainesville.
This article does not in any way signify an endorsement of any particular manufacturer's product.

TIME-TRIED
Diack Controls

LAST NIGHT AFTER WORK

Last night after work several of the nurses were in my room talking over events of the day in Central Supply.

I ran across some unmelted Diacks following one of the autoclavings and one of the girls asked what I did. I said "of course the only thing I could do was re-sterilize the load, paying particular attention to the temperature and timing." The second time the Diacks were melted.

One of the girls in my room was a student nurse and she wanted to know what caused the trouble. Actually I'd apparently forgotten to be sure the outlet thermometer read 250° before I started my timing. The only thing that saved me was that I was using Diacks.

It showed me the main reason most hospitals are using Diacks is that they know when something has gone wrong—either because of the operator forgetting something or because the autoclave itself is out of whack.

SMITH and UNDERWOOD
1841 N. Main St. Royal Oak, Mich.
Sole manufacturers Diack and Inform Controls

to be sharper than conventional needles in a new condition.[2]

Pharmaceutical manufacturers have found the needles to be of such cleanliness that no further processing is required prior to sterilization. The majority of hospitals, however, still include an ether or distilled water rinse before steam or dry-heat sterilization.

The convenience, ease of handling, economy, and safety[2] provided in this form of packaging will assure the disposable hypodermic needle greater prominence in routine clinical and hospital practice.

A symposium on a comprehensive hospital study of disposable needles, now in progress, will appear in an early issue of HOSPITAL TOPICS.—THE EDITORS.

REFERENCES

1. Tinker, R. B., and Hill, R. A., "Tissue Trauma—More or Less?" presented before the American Society of Hospital Pharmacists Annual Convention, New York City, April 30, 1957. To be published.
2. Tinker, R. B., *Bull. Am. Soc. Hosp. Pharmacists* 13:319 (1956).

Cirrhosis Now a Leading Cause of Death

Cirrhosis of the liver ranks among the 10 leading causes of death in the U.S., accounting for 18,000 deaths in 1956. About two-thirds of them were among males.

In the age group 45-64, it is outranked only by heart disease, cancer, and cerebral hemorrhage.

According to Metropolitan Life Insurance Co. statistics, the death rate increases progressively with age in each color-sex group except colored females, among whom deaths level off after middle life.

Improved diagnostic methods have resulted in more frequent reporting of the disease, but increase in infectious and serum hepatitis is also a factor in rise of death rates, as well as reduction in mortality from infectious diseases.

Dietary deficiencies, alcoholism, bile duct disease, chemical toxins and infections, including infectious and serum hepatitis, are believed major contributory causes.

VA Will Train More Occupational Therapists

The Veterans Administration will accept more students for clinical training in occupational therapy to help alleviate the national shortage.

About 300 O.T. students are now being trained at 17 hospitals each year.

Students will receive quarters and subsistence in return for services. Training offers clinical experience in a variety of disease and disability categories. Information may be secured at any VA hospital.

Mental Patients Lecture to Public as Therapy

Patients of Ancora (N.J.) State Hospital are lecturing to the public on mental health in a therapy experiment started by the hospital's director, Harry H. Brunt, M.D.

Because the public knows little about mental illness, Dr. Brunt said, it often regards a discharged mental patient with caution and fear. Since the patient's recovery takes place in the community, the public must be educated, he pointed out.

Dr. Brunt also has made extensive use of patients in detailed administrative work at the hospital. The patients also compose and print a weekly newspaper.

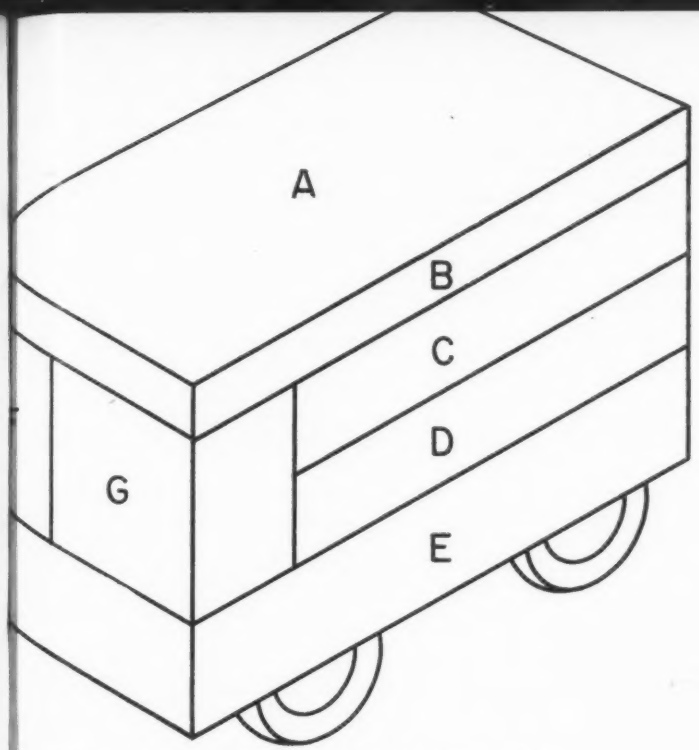
Patients number from 2,200 to 2,500. Three out of four are able to return to their communities after six months.

NEW!
WECK
INSTRUMENT RACK
Insures
COMPLETE INSTRUMENT STERILIZATION!

The 3" pegs on the new Weck Instrument Rack are spaced so the instruments on the rack remain *open*. Hence every portion of each instrument can be thoroughly saturated by steam under pressure for complete sterilization. The holes at both ends enable the rack to be hung up or even screwed to the wall when the rack is used for instrument storage.

The Weck Instrument Rack is 5" long and is sturdily made of Weck Stainless Steel to last and last. As shown, it easily holds practically all sizes of ring-handled instruments – and in quantities up to one dozen.

67 years of knowing how
EDWARD WECK & CO., Inc.
135 Johnson St., Bklyn 1, N. Y.



Scale: 1" - 16". Length—53"; width—29½"; height—43".

A. TOP SHELF:
24 2cc. syringes; 2 5cc. syringes; 1 tray—2 10cc. syringes and 1 boat of syringe cleaner; 1 20cc. syringe, 2 insulin syringes

B. DRAWERS:
Nos. 1 and 2, needles; 3 and 4, catheters; 5, applicators, tongue blades; 6, sterile gloves; 7, sterile towels, suture sets, fluff gauze; 8, combine pads; 9, bandage, sterile medicine glasses; 10, adhesive tape; 11, soap; 12, large sterile dressings

C. SECOND SHELF:
Sponges—boxes of 24; unsterile supplies—like safety pins, etc.; sterile bulb syringes

D. THIRD SHELF:
Douche and catheter trays

E. FOURTH SHELF:
Intravenous solutions and sets; sterile cottonball cans; flasks of sterile normal saline and sterile water; bags for wrappers

F. 20" DEEP DRAWER:
Large sterile dressings

G. SHELF IN FRONT OF DEEP DRAWER:
Alcohol, drinking tubes, Mercressin, tincture of Benzoin

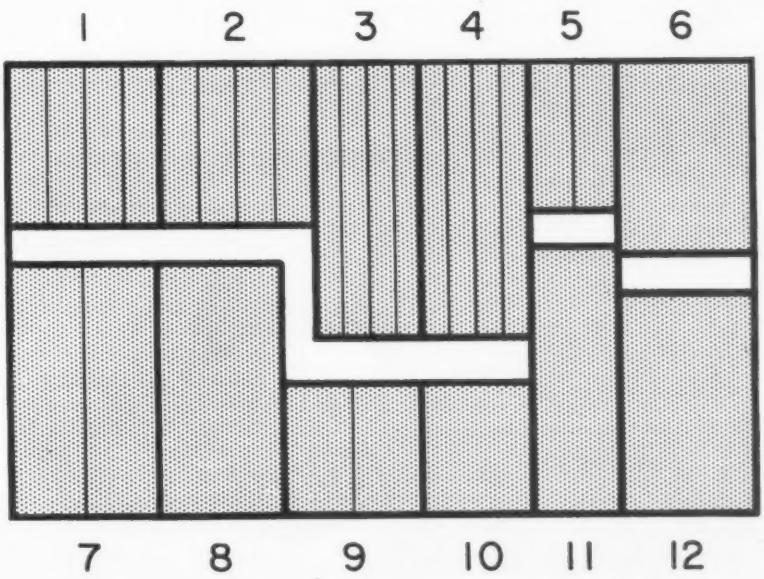
Hospital-Designed Delivery Cart

The central service supply cart shown here was designed to provide pick-up and delivery service for the floors in the 100-bed Champlain Valley Hospital, Plattsburg, N.Y.

The cart makes two trips daily—at 8:30 a.m. and 1 p.m. Syringes, needles, thermometers, catheterization and douche trays, hot-pack trays, dressings, and intravenous solutions and sets are left on the floors in standard amounts.

White charge slips are available on each floor for ordering extra supplies. They are used to charge dressings and intravenous solutions used by each patient.

The cart was built by the hospital's carpenter, at an estimated cost of $155. The drawings and pictures were sent in by Sister St. Marie, who says that the cart conserves time of floor personnel and central service staff and gives the department better control of supplies used.



At right is a diagram showing the 12 drawers (Section B of cart). Dimensions are:

Nos. 1 and 2—length, 6"; width, 8½"-height, 4"
Nos. 3 and 4—18" x 8¼" x 4"
No. 5—8" x 3½" x 4"
No. 6—12" x 9" x 4"
Nos. 7 and 8—18" x 8½" x 4"
No. 9—8" x 8¼" x 4"
No. 10—8" x 8" x 4"
No. 11—18" x 3⅓" x 4"
No. 12—14" x 3½" x 20"

THE LAB

(Continued from page 128)

(3) Doing such associated laboratory tasks as preparing media, washing glassware, sterilizing tests tubes, and sharpening needles.

It is usually found that, in institutions in which technicians spend a large proportion of their time (in excess of 30 percent) on these activities, personnel turnover is higher than in those in which less time is spent on nonprofessional activities.

Certain activities performed by technicians can be avoided. Such activities as washing glassware, preparing media, sterilizing test tubes, and sharpening needles can be assigned, under proper supervision, to nonprofessional personnel trained for these tasks.

A laboratory often not only keeps a copy of the requisition with the laboratory findings entered on it, but also records the findings in a laboratory logbook. This duplication is unnecessary and costly. At the same time, care must be taken to maintain proper and adequate records to abide by the rules and regulations of the various governmental agencies which require certain records. Where possible, these records should be consolidated.

It is good practice for the laboratory to keep a duplicate copy of the report, filed alphabetically by the patient's name, the avoid the necessity of posting findings in a logbook. A number of hospitals have found that even a duplicate file in the laboratory is unnecessary, and rely on filing the laboratory reports in the patient's records.

A generally accepted procedure is to provide space on the requisition originating on the patient's floor for recording the laboratory findings. This requisition is sent in duplicate or, sometimes, in triplicate to the laboratory, where, after the findings are entered, the second copy is filed alphabetically, the original is sent back to the patient's floor, and the third copy, if one is provided, is sent to the business office.

Sound analyses of the laboratory operations will simplify work, reduce costs, and eliminate excessive subjective supervision. With standards of performance, personnel requirements can be definitely determined, and efficiency of personnel can be effectively evaluated.

KEEPING TAB ON LAB

(Continued from page 129)

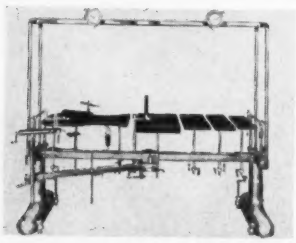
One of the first important undertakings of the council will be its nationwide survey of blood-banking institutions and facilities. Some 10,000 questionnaires have been sent to hospitals and clinics to determine the sources of blood used for transfusion purposes and the number of transfusions which have been administered. A U.S. Public Health Service grant is financing this two-year study, which will include the census of collection and distribution facilities; development of solutions for nomenclature problems; the inventory of the research; compilation of a glossary of terms, and preparation of standards for blood-bank accreditation.

The Joint Blood Council is in a position to study the various problems of blood-banking operations as well as the training of blood-bank personnel. A great deal of valuable information will no doubt be derived from its program. All hospitals, therefore, should cooperate with its methods of research in every possible way.

CHICK

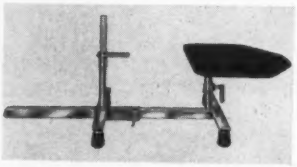
orthopedic, fracture and surgical tables

for every need and price . . .

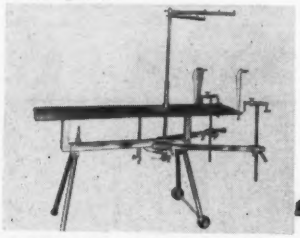


Large and small institutions alike find in the CHICK line of orthopedic, fracture and surgical tables, equipment that is suited to their individual needs. In fact, so much so, that today, these CHICK tables have been installed in more than 50% of America's general hospitals.

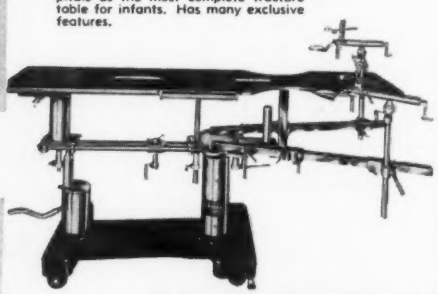
BELL FRACTURE AND ORTHOPEDIC TABLE
This table's flexibility, simplicity, efficiency, and adaptability has warranted its world-wide use during the past 25 years. It is the perfect cast and hip nailing table.



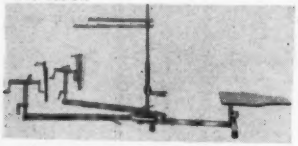
CHICK VARIETY INFANTS CAST TABLE
Tested and proved by hundreds of hospitals as the most complete fracture table for infants. Has many exclusive features.



DOCTOR VIRGIN FRACTURE TABLE
This is a straight fracture table especially designed for use in small hospitals and clinics. Has many features usually found only on the most expensive tables.



DV ORTHOPEDIC AND SURGICAL TABLE
The last word in flexibility . . . a compact, space-saving table, for both operating and fracture rooms. It embodies the latest achievements in x-ray techniques for hip nailing.



CHICK PORTABLE FRACTURE TABLE
The ideal table where portability is a factor, can be handled easily by one person . . carried even in the smallest car.

GILBERT HYDE CHICK COMPANY

MAIN OFFICE AND FACTORY: 821-75TH AVENUE, OAKLAND 21, CALIFORNIA
GENERAL SALES OFFICE: 5 BROADWAY, EAST PATERSON, NEW JERSEY

What if a sudden shock moved the surgeon's hand?

A muscular spasm caused by a static electric shock might prove disastrous. Your conductive flooring can't protect you from the hazards of static electricity unless it is properly maintained.

That's why leading manufacturers, i.e., Congoleum-Nairn, Hubbellite and others, recommend the *exclusive* use of LEGGE materials on their conductive floorings.

Specialists in conductivity for 23 years

Since 1934, LEGGE has pioneered in the development of conductive seals, polishes and cleaners designed to retain the conductivity of your floors. Our staff of specialists is trained in every phase of conductive floor maintenance.

For the sake of safety in your operating rooms, don't fail to write for our descriptive brochure, *"One Little Spark"*.

Walter G. LEGGE Co., Inc.

Dept. HT-10,
101 Park Ave.,
New York 17, N. Y.

Branch offices in principal cities.
In Toronto—
J. W. Turner Co.

CLINICAL NOTES

(Continued from page 88)

Comparison of Sedatives

Results of a study comparing the sedative properties of chloral hydrate, ethinimate, pentobarbital, and a placebo are reported by Kraft, Wolff, and Eckenhoff in the May-June, 1957 issue of *Anesthesia and Analgesia*.

A total of 425 doses was administered to 69 subjects. Doses of 100 mg. of pentobarbital appeared most effective for bed patients in promoting sleep with minimal side reactions.

Ethinimate seemed most effective for ambulatory persons in 500-mg. doses, because of its high incidence of sleep production and considerably lower incidence of side-reactions compared with pentobarbital. It proved superior to chloral hydrate both in producing sleep and in minimizing side-reactions.

Bedfast patients presented a clearer sedative response to drugs, but ambulatory patients gave a higher reaction rate.

Responses of the same patients to two separate but identical doses of the same sedatives varied as much as 35 percent.

Muscle Spasm Reduced

Administration of the oral muscle relaxant zoxazolamine* has resulted in a "markedly increased" ability to function among a group of geriatric patients with neurologic, orthopedic, and arthritic disorders, writes Settel in *The American Practitioner and Digest of Treatment* 8:443.

The 48 patients studied were from 48 to 87 years of age.

Seven of eight patients with acute and chronic recurrent low-back syndrome showed visible, objective improvement, Settel says—the acute cases within three to four days of therapy and the chronic cases after one or two weeks.

Six of the seven patients with acute torticollis got relief in three to four days. All five patients with multiple sclerosis showed measurable diminution of painful spasticity after one to three weeks of therapy on a dosage of 500 mg. t.i.d.

*Flexin (McNeil).

Why not have
a personal subscription
to **HOSPITAL TOPICS?**
One year—$3.50
Three years—$8.00

SAFE—CONVENIENT DISPOSABLE

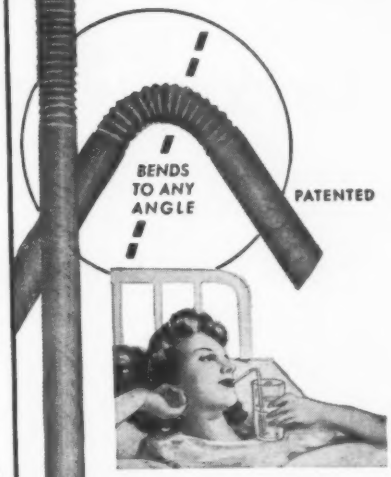
INDISPENSIBLE FOR PEDIATRIC, COMMUNICABLE DISEASES AND PSYCHIATRIC WARDS

AVAILABLE EITHER UNWRAPPED OR IN INDIVIDUAL, SANITARY WRAPPING

FLEX-STRAW®

THE ALL-PURPOSE, DISPOSABLE DRINKING TUBE

for use in both HOT and COLD LIQUIDS



ELIMINATES STERILIZATION, BREAKAGE and ACCIDENTS

•

SAVES TIME AND MONEY

•

BOTH UNWRAPPED AND INDIVIDUALLY WRAPPED

•

PACKED 500 TO BOX
20 BOXES TO CASE OF 10,000

CANADIAN DISTRIBUTORS—
INGRAM & BELL, LTD.
HEADQUARTERS, TORONTO

ORDER FROM YOUR AREA DISTRIBUTOR TODAY

FLEX-STRAW CO.
CLEVELAND 3, OHIO

Look how fast you can safely seal and label autoclave packages!

A PAIR OF GLOVES
A SANITARY PACKAGE
A COMMUNICATION

} ALL IN ONE *FAST* OPERATION

Fast, convenient Time Labels cut packaging and labeling work in half. Eliminates extra folding and tucking. Pre-printed titles eliminate errors, confusion and waste. Time Labels are on tough Vinyl coated paper for every hospital department. Holds thru all standard autoclave processes. Seals cloth, paper or plastic.

TIME LABELS ARE SAFE!

. . . did you know that over 40 papers have been written on personnel safety the past 5 years? Write for summary of articles . . . "LABORATORY ACQUIRED INFECTIONS" by Dr. Kenneth Costich.

LET US PROVE IT . . .

See for yourself how you can increase speed and safety in your HOSPITAL DEPARTMENT

Write for free sample, literature and prices.

Professional Tape Co. Inc.
Box 41-K
355 East Burlington
Riverside, Illinois

ADVERTISER'S INDEX

Acme Cotton Products Co., Inc. 44
Aeroplast Corp. 33
Air-Shields, Inc. 85
A. S. Aloe Co. 41
American Cynamid Co. 27, 57, 118, 119
American Cystoscope Makers, Inc. 121
American Hospital Supply Corp. 64, 65
A•S•R Products Corp. 117
American Sterilizer Co. 36
Gordon Armstrong Co., Inc. 94
C. R. Bard, Inc. 16
Bard-Parker Co., Inc. ..... 3rd cover
Bauer & Black 61
Baxter Laboratories 54, 55
Becton, Dickinson & Co. 4
Dorothea Bowlby Associates (classified) 62
Carolina Absorbent Cotton Co. ..... opposite page 56
Wilmot Castle Co. 73
Chesebrough-Pond's, Inc. 86
Ciba Pharmaceutical Products, Inc. 49
Classified 51, 55
Clay-Adams, Inc. ..... 2nd cover
Cutter Laboratories 106
Davol Rubber Co. 42
J. A. Deknatel & Son, Inc. 15
DePuy Mfg. Co., Inc. 127
Desitin Chemical Co. 87
Dittmar & Penn Corp. 39
Doho Chemical Corp. 11
Ethicon, Inc. ..... opposite page 16
Everest & Jennings 88
The Fengel Corp. 46
Flex-Straw Co. 32, 135
Gilbert Hyde Chick Co. 134
Gudebrod Bros. Silk Co., Inc. 8
Thomas W. Halliday 30, 47
Hausted Mfg. Co. 1
Hill-Rom Co., Inc. 105
Homemakers' Products Corp. 89
HOSPITAL TOPICS 40
Huntington Laboratories 128
Mary A. Johnson Associates (classified) 55
Johnson & Johnson ..... 55, opposite page 104
Kaye Thermometer Corp. 47
Kremers-Urban Co. 122
Lakeside Laboratories ..... 4th cover
Walter G. Legge Co., Inc. 135
Lehn & Fink Products Corp. 104
Eli Lilly & Co. 6
The Lin Co. 102
Lurline Products Co. 59
The MacBick Co. 130
MacGregor Instrument Co. 12
Massillon Rubber Co. 97
Meinecke & Co., Inc. 10
Miller Sewer Rod Co. 62
V. Mueller & Co. 52
Ohio Chemical & Surgical Equipment Co. 63
Parke, Davis & Co. 5
The Pelton & Crane Co. 129
The Pioneer Rubber Co. 90
Professional Tape Co., Inc. 136
Roche Laboratories, Division of Hoffmann-LaRoche, Inc. 34
Shampaine Co. 13
Shay Medical Agency (classified) 51
Smith & Underwood 132
Snowden Instrument Co. 102
Sterilon Corp. 60
Travenol Laboratories, Inc. 98
Edward Weck & Co., Inc. 14, 132
West Disinfecting Co. 35
Winthrop Laboratories 120
Zimmer Mfg. Co. 96

B-P
HALIMIDE*

the CONCENTRATE with the TWOFOLD ACTION

For Instrument Disinfection

*Trademark of Bard-Parker Co., Inc.

BACTERICIDAL—when diluted with water
(except the tubercle bacillus)

TUBERCULOCIDAL *also*—when diluted with alcohol

PLUS—these other important advantages . . .

NON-CORROSIVE—No anti-rust tablets to add.

STABLE—Need not be changed frequently.

ECONOMICAL—1oz. makes 1 gal. of solution.

Bard-Parker HALIMIDE is the result of years of research to develop a concentrate combining maximum bactericidal potency and trouble-free performance. IT'S ECONOMICAL . . . *any way you look at it!*

LIST PRICE—4 oz. bottle $2.50

Please see your Dealer for quantity discounts or discounts applicable when purchased on Annual Hospital B-P Blade Contract or with other B-P Products.

PARKER, WHITE & HEYL, INC.
Danbury **Connecticut**

B-P INSTRUMENT CONTAINER No. 300

Of stainless steel and PYREX glass with airtight cover. Ideal for use with B-P HALIMIDE.

HALIMIDE and your INSTRUMENTS . . . . THEY COMPLIMENT EACH OTHER

in the hospital the diuretic must work

If the first diuretic used in the patient hospitalized for heart failure is ineffective, it may be too late to try another. For this reason and many others, physicians prefer the dependability of injected MERCUHYDRIN.®

Experience with innumerable patients in several decades of use confirms the uniformly rapid response to MERCUHYDRIN with a minimum of side effects. This assured action saves lives, saves time, saves money. And when recovery is well underway, switching to oral NEOHYDRIN® has the further advantages of saving injections for the patient and time for your nursing staff.

LAKESIDE

A STANDARD FOR INITIAL CONTROL OF SEVERE FAILURE

MERCUHYDRIN®

BRAND OF MERALLURIDE INJECTION SODIUM

FOR MAINTENANCE OF THE EDEMA-FREE STATE

NEOHYDRIN®

BRAND OF CHLORMERODRIN TABLET

15587